Democratic Republic of Congo

Country Operational Plan

(COP/ROP) 2016

Final Strategic Direction Summary

June 24, 2016

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GOAL STATEMENT

The PEPFAR FY17 plan in DRC builds upon a series of strategic pivots that began in 2013, which reduced PEPFAR's intervention zones from seven to four provinces in COP13, and from four to three provinces in COP14. On July 16, 2015, the government of the DRC implemented a decentralization project which led to an increase in the number of provinces in the DRC – the number officially grew from 11 to 26. The boundaries of these 26 provinces will follow current administrative divisions mainly employing "districts" to form new provinces. Therefore, Katanga was divided into 4 provinces: Haut-Katanga, Lualaba, Tanganyika and Haut-Lomami and Orientale was split into 4 provinces: Tshopo, Ituri, Haut-Uele and Bas-Uele. On October 9, 2015, the Ministry of Health, the Global Fund to fight AIDS, Tuberculosis and Malaria, and PEPFAR signed a memorandum of understanding to rationalize their investments in order to improve efficiency and coordination. Stakeholders agreed on "one donor per health zone" principle and divided the newly created provinces among them. Kinshasa will be the only place where two donors will be co-located. Thus in FY 17 PEPFAR will be implemented only in Haut-Katanga, Lualaba and some health zones of Kinshasa where HIV prevalence is higher than the national average: Kinshasa, 1.6%, Haut Katanga 1.5%, and Lualaba, 1.5%. The estimated number of PLHIV living in these three provinces represents approximately 40% of the total number of PLHIV in DRC (Spectrum 2015). The FY17 plan also supports efforts of the government of the Democratic Republic of Congo (GDRC) to "rationalize" HIV/AIDS donor aid by assigning one donor per health zone (HZ) by December 2016 and one donor per provincial health division (French: Division Provinçiale de Santé (DPS) by December 2018.

In FY17, PEPFAR DRC will support activities in 47 + 1 military cluster out of 516 health zones in the country. Of these 47 HZs, 17+1 military cluster are being scaled up to achieve Saturation, and 30 will be maintained as Sustained. A number of HZs (46) that were previously supported by PEPFAR will be completely transitioned to the Global Fund (43 HZs) and the GDRC (3 HZs) by the end of 2016. To facilitate analysis, and because of the close proximity of HZs, PEPFAR DRC has grouped priority HZs into six clusters: Kinshasa and Haut Katanga Saturation Clusters; Kinshasa, Haut Katanga and Lualaba Sustained Clusters; and a military cluster. The goal of the PEPFAR DRC strategy is to achieve sustained epidemic control in 17 HZs (Kinshasa and Haut Katanga Clusters) and 1 military cluster (17+1) by September 30, 2017. To reach 80% ART coverage in these priority HZs, PEPFAR DRC will contribute to providing care and treatment services for 31,539 people (9,109 newly enrolled) in FY16, and for 45,736 (saturation TX CURR) people (17,114 newly enrolled) by the end of FY17. In Sustained HZs, PEPFAR DRC will continue to ensure access to the government's basic package of facility-based prevention, treatment and follow up services for pregnant women, families of PLHIV, children, and other high risk groups. In sustained zones, PEPFAR expects to support 26,020 on treatment (6,504 newly enrolled). Expected achievements reflect the implementation of new WHO guidelines by the GDRC in 2016, by putting all new HIV positive patients on Anti-retroviral (ARV) therapy immediately (Test and Start);

using new optimized service delivery models to increase access to services, improve efficiencies, increase retention, and scaling up Viral Load (VL) testing.

In an effort to maximize available resources and increase impact, the PEPFAR program is focusing efforts on building capacity and reducing barriers to improve access and uptake of HIV prevention, care, and treatment services in priority intervention zones. At the site level, PEPFAR is using results from the Site Improvement through Monitoring System (SIMS), quarterly data reviews, and partner reports to monitor trends and tailor technical assistance activities. Using the Systems Business and Optimization Review (SBOR) approach, PEPFAR is ensuring that health system strengthening activities are strategically addressing key program gaps that are hindering the achievement of 90-90-90 and sustained epidemic control. Through site-level and systems-level support, PEPFAR DRC will focus FY17 efforts on:

- Improving treatment outcomes through the timely procurement and distribution of antiretroviral drugs (ARV) and establishing strong linkages to treatment, care, and retention.

- Using innovative strategies to identify people living with HIV (PLHIV), and facilitate easier access to services through optimized service delivery models.

- Supporting size estimation and behavior studies to identify and reach key populations (female sex workers and MSM) with tailored services that address their specific needs.

- Coordinating with the Global Fund and other donors to maximize Health System Strengthening (HSS) investments, with a focus on the supply chain for HIV-related commodities, the national health information system (NHIS), and national laboratory systems.

- Ensuring the provision of care and support services for orphans and vulnerable children (OVC), by improving clinical site linkages with community services focused on OVC.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

The HIV epidemic in DRC is generalized, with a prevalence of 1.2% (0.6-1.7% ages 15-49) based on 2015 UNAIDS estimates (version 5.30), with 560,798 people living with HIV out of an estimated population of 74.6 million**.** Prevalence is higher in urban (1.7%) versus rural areas (0.6%) and slightly higher among women than men 15 years and older (1.09% vs. 0.77%). According to UNAIDS, a majority of HIV transmission in DRC is through heterosexual contact, exacerbated by high-risk sexual practices (such as multiple concurrent partners) and low or inconsistent condom use. Although there is insufficient data on the location, typology, and dynamics of key populations and high-risk groups, prevalence among Female Sex Workers (FSWs) is estimated at 9.8% in Kinshasa and 10.8% in Katanga (IBBS 2013), two of the highest-burden areas. TB prevalence in DRC is 549 per 100,000 and nationwide only 44% of TB patients know their HIV status, even though TB remains the primary cause of death among HIV-positive patients. Of the 14% of TB patients co-infected with HIV, approximately 48% are on ART (WHO, Global Tuberculosis Report, 2014).

Population size, poverty scale, and decades of conflict have resulted in DRC's lack of a cohesive and functional health system. The SBOR analysis for COP16 identified systemic weaknesses that include a fractured and unresponsive supply chain, weak laboratory and sample transport systems, slow and incomplete information management systems, and the lack of institutionalized quality assurance systems across all areas of the program - all factors hindering the achievement of epidemic control.

There has been some improvement in data transmission and reporting from sites to the provincial and national levels. However, reporting on key indicators, such as the number of infants tested for HIV and the number of PLHIV that reach viral load suppression, remains limited, primarily due to insufficient distribution and use of new tools and registers by providers. Efforts have been made to introduce electronic reporting systems such as the Monitoring Evaluation and Surveillance Interface (MESI), but operation has been slow due to poor internet connectivity, slow deployment and limited support at the HZ level. Access to healthcare services is complicated by poor infrastructure, including inadequate roads and the lack of electricity and water at many health facilities.

It is important to note that DRC is at a pivotal moment in history, faced with a difficult democratic transition. Presidential and legislative elections are scheduled for November 2016, but concerns are growing as 2016 progresses along with the likelihood of general unrest and interruptions to the provision of public services, including HIV-related health services.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	74,680,436	100	17,176,500	23	16,429,696	22	20,910,522	28	20,163,718	27	INS SPECTRUM 2015 Version 5.31
Prevalence (%)		1.2		N/A		N/A		1.6		0.6	DHS 2013 Report
AIDS Deaths (per year)	25,505		2,357		2,393		10,385		10,370		SPECTRUM 2015 Version 5.31
PLHIV	560,798		35,288		36,595		296,684		284,921		DHS 2013 Report SPECTRUM 2015 Version 5.31
Incidence Rate (Yr)		N/A		N/A		N/A		N/A		N/A	
New Infections (Yr)	32,674										SPECTRUM 2015 Version 5.31
Annual births	2,987,217	4									SPECTRUM 2015 Version 5.31
% >= 1 ANC visit	2,419,646	81	N/A	N/A			N/A	N/A			2012 PNSR Annual report

Pregnant women needing ARVs	53,770	1.8									2013 ANC SS
Orphans (maternal, paternal, double)	28,132		N/A		N/A		N/A		N/A		SPECTRUM 2015 Version 5.31
TB cases (Yr)	116,894		N/A		N/A		N/A		N/A		2015 Global TB report
TB/HIV Co-infection	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Males Circumcised	34,461,758	97			N/A	N/A			N/A	N/A	DHS 2007 Report
Key Populations	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Total MSM*	N/A	N/A									
MSM HIV Prevalence	N/A	N/A									
Total FSW	N/A	N/A									
FSW HIV Prevalence	N/A	6.9									IBBS 2013
Total PWID	N/A	N/A									
PWID HIV Prevalence	N/A	N/A									
Priority Populations Prevalence											
Truck drivers	N/A	1.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013
Miners	N/A	1.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013

Youth (street children)	N/A	1.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013

1.2 Investment Profile

The Democratic Republic of Congo (DRC) has one of the lowest gross national incomes (GNI) per capita in the world ($740), with an estimated 63.6 percent of the total population of 74.6 million living below the poverty line (World Bank, 2014). According to the African Development Bank (AFDB) 2014 report, DRC's economic growth rate has increased slightly from 8.1% in 2013 to 8.2% in 2015. However, the benefits of this economic growth are spread unevenly across the population, and the United Nations Development Index 2015 ranks the DRC as one of the least-developed countries in the world (176/188).

According to the most recent National AIDS Spending Accounts (FRENCH: 'REDES' 2013-2014) and the UNAIDS investment case, the HIV response is mostly funded by donors (42.66%), private/households (43.67%) and government (13.67%). Although still limited, the GDRC investment in HIV/AIDS has increased by 1.41% since 2010. The US Government's support to DRC through PEPFAR has increased significantly from $45 million USD (2014) to $61 million USD (2015) and $66 million (2016), in line with the investment approach guiding the PEPFAR 3.0 strategy. Under the GF Country Coordinating Mechanism (CCM) leadership, three DRC HIV and TB grants have begun implementation, for a total of 182 million USD for three (3) years ($60.5 million USD per year for calendar years 2015, 2016, and 2017). PEPFAR is working with the Global Fund country team and the National AIDS Control Program (FRENCH: 'PNLS') to eliminate duplication through the rationalization process, and to strategically align with domestic and other available resources to maximize joint investments.

Before the rationalization process, the Global Fund procured the majority of HIV- related commodities for the DRC, while PEPFAR made targeted investments in drugs and commodities focused on PMTCT. As PEPFAR DRC has pivoted from a focus on PMTCT to the whole continuum of care and treatment services, so have its commodities investments. Starting in FY17, each donor will be responsible for the provision of ARVs and other commodities to patients in their HZs. As a result of this, as well as the GDRC decision to implement test and start in 2016, PEPFAR investments in HIV-related commodities will increase in alignment with the increasing patient load in priority HZs. Efficiencies and savings gained from ended activities in the Orientale province, as well as an additional one-time $4 million USD in 'Impact Funds' for COP16, will allow the program to afford this increased investment in commodities, and be accountable for the supply chain process in priority health zones from forecasting to last-mile distribution, working primarily through provincial authorities and regional warehouses. The GDRC and partners such as UNICEF, UNFPA and the private sector, will continue to purchase approximately 15% of HIV-related drugs and commodities.

Non-PEPFAR United States Government (USG) investments in health are significant. In FY16 and FY17, USAID is investing $124,750,000 in non-HIV programming, and $18,734,000 in co-funding for fourteen (14) PEPFAR implementing mechanisms. CDC is also investing $300,000 for supportive supervision. However, the geographic coverage of these mechanisms only overlaps in the Katanga province.

Last year, the GDRC signed a document demonstrating 'proof of willingness' to provide $60 million USD as a co-investment for new Global Fund grants. Despite this commitment, there are insufficient domestic resources available to fill funding gaps in the immediate future. To achieve a sustainable response, PEPFAR will strengthen collaboration with other national-level donors to advocate for progressive increases in domestic resources for health and HIV/AIDS. This collaboration will also focus on establishing and strengthening a GDRC-led national forecasting and procurement system for health commodities, addressing task-shifting and other key human resource gaps, and ensuring the community systems strengthening necessary for an effective continuum of care in line with the country's 90-90-90 goals.

As feasible, PEPFAR is planning for the possibility of political unrest, increased violence, and protests either before or after the November 2016 Presidential elections, which may affect the implementation of activities. In addition, the transfer of supply chain support from one major partner to another between FY16 and FY17 may impact supply chain activities, although every effort is being made to plan for a smooth transition.

Table 1.2.1 Investment Profile by Program Area[1]

Program Area	Total Expenditure ($)	% PEPFAR	% GF	% GDRC	% Other
Clinical and Community care, treatment and support	$27,211,579	35%	53%	9%	3%
PMTCT	$25,452,111	46%	30%	0.13%	24%
HTC	$10,788,736	35%	65%	0%	0%
Prevention for other priority populations	$9,144,427	25%	51%	0%	23%
Key population	$4,583,540	73%	5%	0%	22%
OVC	$1,726,108	100%	0%	0%	0%
Laboratory	$2,524,425	100%	0%	0%	0%
SI, Surveys and Surveillance	$4,947,183	5%	59%	22%	14%
HSS	$21,006,346	18%	53%	18%	12%
Total	$107,384,455				
% of Total		36%	45%	7%	12%

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	37,129,011	9.70	90.30	0	0
Rapid test kits	8,602,982	12.79	86.01	0	1.21
Other drugs	11,369,662	4.91	38.53	20.23	36.33
Lab reagents	2,126,438	13.01	74.19 91.30	0	12.8
Condoms	5,710,017	0		5.78	2,92
Viral Load commodities	3,833,604	0.00	91.46	0	8,54
VMMC kits	0	0.00	0	0	0
MAT	249,227		0	0	100
Other commodities	1,254,835	22,07	77.93	0	0
Total	70,275,779	5,812,322	56,584,263	2,630,000	5,249,194

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$34,750,000	$3,640,000	4	$6,092,000	Integrated behavior change (IBC), clinical, and supply chain (SC) strengthening services
USAID TB	$13,000,000	$1,800,000	2	$1,100,000	Prevent and treat TB and ensure strong referral for HIV/TB co-infected patients; national and provincial TB-HIV coordination
USAID Malaria	$50,000,000	$3,640,000	1	$2,150,000	IBC, clinical, and SC strengthening services
USAID FP	$16,700,000	$2,100,000	4	$6,092,000	IBC, clinical, and SC strengthening services
USAID Nutrition	$2,000,000	$300,000	1	$1,650,000	Integrated nutrition services in primary care platform
USAID WASH	$8,000,000	$800,000	1	$1,650,000	IBC and WASH services
CDC	$300,000		1	$1,200,000	Improve supportive supervision and quality assurance activities at clinical sites
Total	**124,750,000**	**12,288,000**	**14**	**19,934,000**	

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT (Accelerating Children on Treatment)	$7,996,381	–	–	8	$2,800,000	The ACT initiative aims to double the number of Children Living with HIV/AIDS (CLWHA) on treatment in DRC.
'EAGLE' Central Funds	$5,000,000	–	–	1	–	IBC and GBV prevention services.
PEPFAR DRC Public Private Partnership with Becton Dickson		$35,000	–	1	$20,000	To improve laboratory quality and sample transport systems
Total	$12,996,381	$35,000	–		$2,820,000	

1.3 National Sustainability Profile

The Sustainability Index Tool (SID) was designed by PEPFAR to help countries assess progress towards a sustainable national response. The COP16 tool was completed following a four-day process, during which representatives from civil society, government, and the United Nations reviewed and discussed the four major components essential for sustainability: 1) Governance, Leadership and Accountability; 2) National Health System and Service Delivery; 3) Strategic Investments, Efficiency, and Sustainable Financing; 4) Strategic Information. To arrive at the final scores, each question was discussed with supporting documentation collected and reviewed. A version was shared with other civil society actors for review, comment and further inputs before COP submission, and will be discussed with the PNLS, UNAIDS and the Global Fund to help guide future investments.

The SID evaluation process identified two categories that scored light green and are considered 'on track' towards being sustainable. They are: 1) Planning and Coordination and 2) Public Access to Information. It should be noted that the tool evaluates the existence of plans, planning documents, policies, etc., but does not assess the level of implementation of these plans, which is a concern in DRC. Furthermore, planning and coordination does not yet exist across all key areas. TB/HIV coordination remains a challenge that we plan to address in the FY16 COP. Other categories identified as moderately sustainable included financial expenditures, performance data, and civil society engagement.

Areas identified as the least sustainable include domestic resource mobilization, commodity security and supply chain, quality management, and technical and allocative efficiencies. In these areas, PEPFAR DRC will continue to prioritize activities that will reinforce commodity security and the supply chain, and the improvement of quality through more regular site visits (SIMS) and the installation of quality assurance procedures at all PEPFAR supported sites. PEPFAR investments have only recently expanded beyond PMTCT to include the full spectrum of care and treatment services, and quality assurance will become increasingly important as the program focuses on improving results in all areas to achieve 90-90-90. For supply chain systems, PEPFAR investments to date have been modest, but will increase significantly in COP16, as this remains a major program gap. Although categorized as 'yellow', or moderately sustainable, improving epidemiological and health data, through system support to improve national health information management systems, will be a major focus of PEPFAR. Other areas, such as MESI, the inclusion of data entry clerks into the national human resources for health 'cadre', reinforcing national survey and surveillance systems, and supporting quarterly provincial data review meetings will also be prioritized by PEPFAR. (see Section 6.0 for more details).

Global Fund investments target provincial and health zone level health administrators with managerial and technical capacity for support and funding. The goal is to improve quality, data availability and use, planning and coordination. Given SID results, specific discussions with PEPFAR are ongoing to coordinate and align efforts to improve the quality of services being offered at the HZ levels, as well as site-level. The Global Fund did obtain a promise of increased domestic resource support by acquiring a signed commitment of co-investment for $60 million USD that accompanied the 2015-2017 Global Fund grant documents.

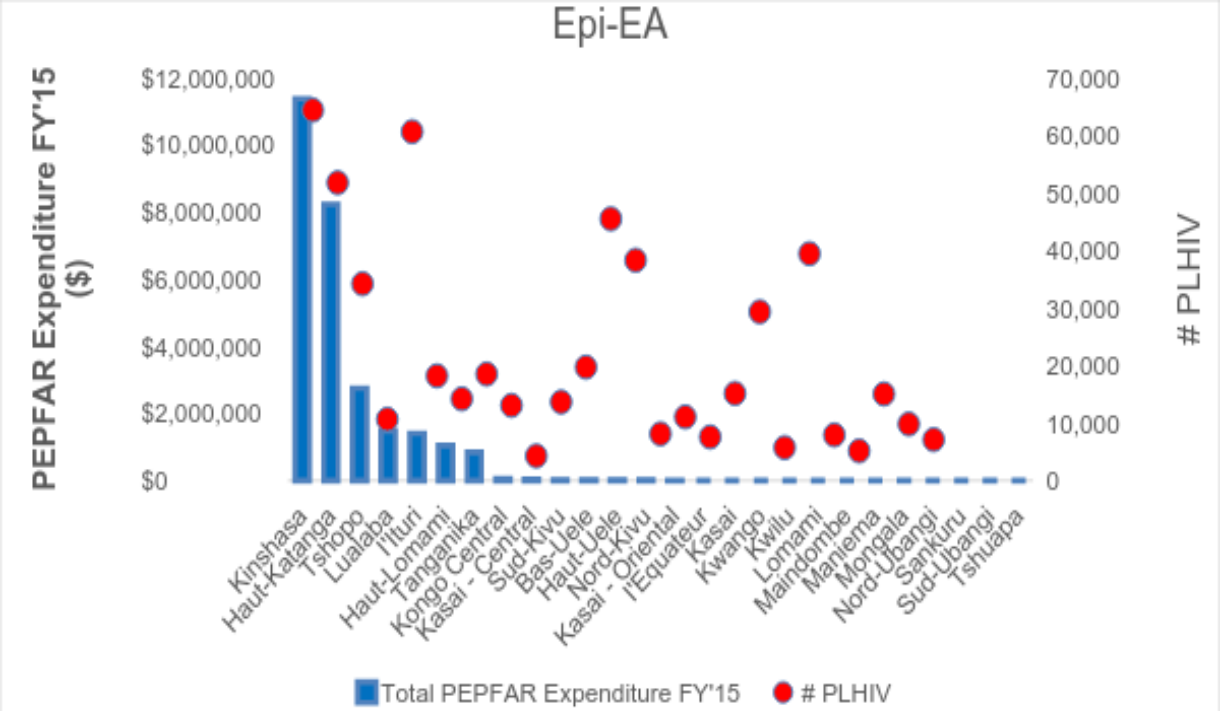
Note: Results of the Systems and Budget Optimization Review (SBOR) (program support and systems level interventions) are described further in section 6.0.

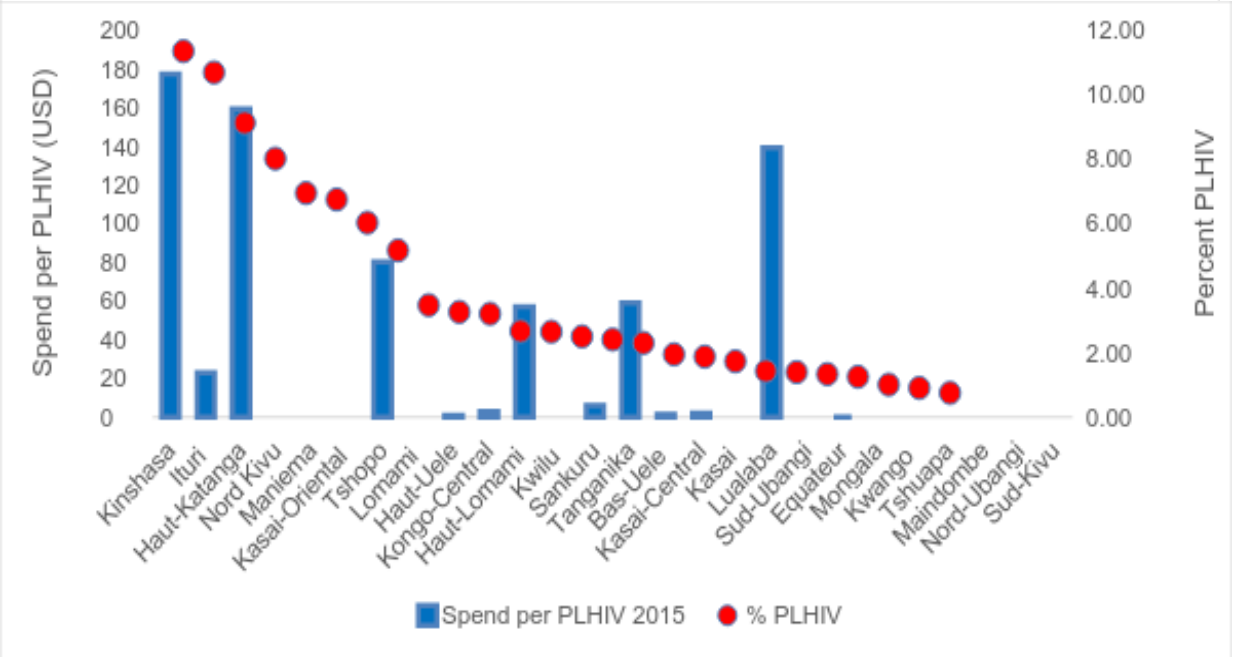
1.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR DRC is shifting resources and expenditures to scale-up to Saturation and Sustained Support areas. Following decisions made in COP 15 to prioritize geographic areas, the highest spend in FY'16 will be in these saturation areas. The transition to Global Fund in the PNLS-led rationalization process is set to be completed by end FY16, resulting in PEPFAR focusing primarily in three DPS: Kinshasa and Haut-Katanga (both saturation and sustained support clusters), and Lualaba (sustained support cluster). Expenditures in non-PEPFAR focus areas represent targeted testing and counseling activities with the military (priority population) as well as prevention expenditures for national radio programming through the Voice of America to disseminate targeted HIV prevention messages.

In FY14 and FY15, PEPFAR DRC transitioned to higher burden HZs, ending activities in Bas Congo, and investing in new activities in Orientale (Tshopo and Ituri). However, in COP 15, due to higher operating costs, these newer activities in Orientale were slated for transition to the Global Fund. This transition will be completed by end of 2016. In other areas such as Kasai-Oriental, Kasai-Occidental, Maniema, Nord-Kivu and Equateur provinces, the Global Fund supports 70% of activities while the UK's Department for International Development (DFID) funds the remaining 30%.

Lualaba will continue to benefit from PEPFAR support as a sustained support cluster due to its strategic importance for epidemic control in the Lubumbashi saturation cluster. PEPFAR activities focus on key population hot spots and are concentrated in the provincial capital city, which is on the primary transportation corridor to and from Lubumbashi. Overall spending rate in Lualaba, as shown in Figure 1.4.2 is lower, relative to PEPFAR spending rates in Kinshasa and Haut-Katanga, reflecting the lower number of PLHIVs in the cluster, in spite of its strategic significance.





1.5 Stakeholder Engagement

PEPFAR DRC consulted with multiple stakeholders in developing the 2016 COP. COP 15 planning focused significantly on the "where", such as geographic prioritization and selecting high burden areas for PEPFAR prioritization. COP16 planning, however, focused mainly on the "how", to improve identification, enrollment on ART, retention of PLHIV, how to support the timely and effective roll out of new WHO guidelines, while ensuring the completion of the national rationalization process, and addressing key program barriers. A visit by the OGAC Chair and Agency Points of Contact from USAID, CDC, and DOD in January 2016, allowed for discussions with representatives from the National TB Program (French: Programme National de Lutte contre la Tuberculose (PNLT)), Multi-Sectorial commission on AIDS (French: Programme National Multisectoriel de Lutte contre le SIDA (PNMLS), UNAIDS, WHO, and the Global Fund, with a specific focus on supply chain planning and support. Results from the Sustainability Index (SID) review process (February 2016) were used to guide SBOR discussions and systems-level investment decisions. In March 2016, the Director of the PNLS participated in a four-day planning meeting with the PEPFAR team in Washington DC, to agree on the overarching strategic direction of COP16, align data use for planning with PNLS expectations, and set overall program targets. Meetings with civil society held in February and March set the stage for a full-day workshop held on April 7, 2016 to solidify recommendations for using innovative community-level approaches to identify PLHIV, improve retention, and clarify OVC support. Specific recommendations included: working with community organizations to help with oversight of ARV stockpiles, ensuring that patient's rights are respected by installing a complaints reporting system through IPs, reinforce community based health care facilities for optimal home based follow-up of patients on ARV's, and ensure a system of permanent linkage of care between communities and health structures. It was also recommended to reinforce the capacity of community based health care practitioners to continue to advocate for the respect and protections of the human rights of PLHIV and other vulnerable populations.

Recommendations from Civil Society are further detailed in the CSO COP16 engagement report, submitted as part of the supplemental documents for DRC for COP 16.

2.0 _ Core, Near-Core and Non-Core Activities

The 'core' package of interventions provided by PEPFAR was revised in COP 15 to include only evidence-based activities that are proven to have an impact on epidemiological outcomes, including combination prevention, targeted prevention to reach priority populations (general prevention programming was phased out), and select investments to reinforce procurement and supply chain, laboratory, and strategic information systems.

The programmatic priorities in COP16 build upon this core package, with the addition of Test and Start, scaling up Viral Load testing, funding clinical partners to provide OVC support, and implementing new optimized service delivery models to increase retention and to reduce the number of patients lost to follow up.

Core activities for COP16 include the following:

- Close the gap in treatment coverage by increasing access and treatment for key and priority populations in priority HZs;
- Increase early initiation and overall coverage of ART for HIV-infected infants, children, and adolescents;
- Increase focus on evidence-based facility and community care and support interventions that have the greatest impact on morbidity and mortality of PLHIV and contribute to ensuring adherence and reducing loss to follow up;
- Continue to focus on targeted prevention activities and strengthen linkage to care, treatment and support services for key and priority populations;
- Improve TB prevention and screening among PLHIV and increase access to ART for HIV- infected TB patients;
- Improve OVC programming by focusing on services for families that have been shown to positively impact children;
- Maintain care and treatment services for HIV positive pregnant women and their exposed infants;
- Strengthen human and institutional capacity for health information systems, including data collection, data quality improvement, data use, and dissemination;
- Strengthen coordination with the Global Fund and GDRC supply chain management platforms to ensure a continuous, responsive, and uninterrupted supply of relevant drugs and commodities.

See Appendix A for a full list of core, near-core, and non-core activities and transition plans. A successful transition of activities depends on the rapid roll-out of new WHO guidelines by the GDRC, including the implementation of Test and Start; successful implementation of the Viral Load and Early Infant Diagnosis Scale-up Plan; continued co-funding of TB activities by USAID; and the successful implementation of the joint Global Fund HIV/TB Concept Note.

3.0 Geographic and Population Prioritization

The COP16 plan builds upon decisions made in COP 15. Last year, PEPFAR DRC went through the process of selecting the highest burden HZs in the country in order to focus efforts on achieving epidemic control. To select the highest burden HZs for scale up to reach 90-90-90, the PEPFAR DRC team categorized all 516 health zones in all 11 provinces of DRC, which have since been reconfigured to 26 provinces, according to the following criteria: disease burden as calculated by SPECTRUM, high unmet need according to PNLS 2014 programmatic data for PEPFAR-supported health zones, and yield of PEPFAR HTC, PMTCT, and ART sites per 2014 PEPFAR Annual Progress Results (APR) data. In

addition, the team considered contextual information, such as the presence of the Global Fund (consistent with the PNLS's rationalization process) and key population and priority population hotspots.

Of the 95 HZs where PEPFAR DRC was supporting services in June 2015, 17 HZs plus one military cluster were designated as priority where activities will be scaled up to achieve epidemic control by the end of FY17. Ten of these HZs plus one military cluster make up the Lubumbashi cluster, a major urban area in Katanga province, with a total population of over 1.7 million. The other seven HZs plus one military cluster make up the Kinshasa cluster. According to Annual Progress Results (APR15) for the number of people currently on treatment (TX_CURR), these clusters represent 52% of PEPFAR DRC's total volume of patients on ART. In order to reach 80% ART coverage in the selected health zones, an estimated 45,550 PLHIV must be on ART by the end of FY17 (COP16 Data Pack).

In addition to these Saturation HZs, hotspots with transport corridors feeding into the urban clusters, which have large numbers of sex workers and clients, and men who have sex with men (MSM), were identified for scale up in five Saturation HZs and nine Sustained Support HZs. Scaling up these hotspots along the border with Zambia is critical to epidemic control due to the transient nature of the population, and high levels of movement through and to the priority urban areas.

PEPFAR DRC will continue sustained support to 30 HZs in Katanga and Kinshasa. By the end of FY17 (September 2017), PEPFAR DRC is expecting to support approximately 26,016 PLHIVs on ARTs in these HZs.

After discussion with the Global Fund and PNLS in July 2015, it was determined that PEPFAR DRC would transition all supported HZs in Orientale to the Global Fund by the end of FY16. This includes five HZs in Tshopo, an urban area, and 10 HZs in Ituri, a mining area along the border of Uganda, with a high concentration of FSWs. The high burden of HIV in Orientale, high unmet need, and nascent service delivery in Ituri required the establishment of a detailed transition plan, which was established under the leadership of the PNLS. The plan is guiding the transition to the end of FY16 with the goal of minimizing impact on patient care and support.

Given the low level of funding provided by GDRC for HIV/AIDS services (see tables 1.2.1 and 1.2.2), the Global Fund's limited budget to support additional services, and PEPFAR DRC's experience transitioning ART patients in FY14, the decision to transition services in Sustained HZs was considered carefully and quality continuation of care for existing patients was the key factor. GDRC, the Global Fund and PEPFAR are committed and are on track to implement the transition plans before September 2016. Of utmost importance is the assurance that individual patients on ART continue to receive quality services during and after the transition.

To determine the sites requiring scale-up, maintenance, or transition of services, PEPFAR DRC examined APR 2015 HTC and PMTCT yield, and ART volume. Special circumstances such as borders, key populations and other vulnerable populations (OVPs), were also considered. Sites with an HTC yield of less than 12, PMTCT yield of less than 8 and with no one on treatment were slated for transition. Sites

with an HTC yield of less than 12, PMTCT yield of less than 8, and ART volume of one or more were slated for maintenance unless ART provision could be adequately assured through transition to the Global Fund or up-referral to a neighboring site; in which case the sites were converted to transition sites. Sites with an HTC yield of 12 or more, PMTCT yield of 8 or more, and ART volume of 5 or more were classified as scale-up sites in priority health zones and maintenance sites in maintenance HZs.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

The PEPFAR DRC team used the PEPFAR Data Pack to set program area targets in five clusters: two saturation clusters (Kinshasa and Lubumbashi) and three sustained support clusters (Kinshasa, Haut-Katanga, and Lualaba). FY17 targets reflect Test & Start, as DRC is on track to implement Test & Start by the end of FY16. PEPFAR DRC intends to enroll 23,618 patients on treatment in FY17. Combined with an estimated 80% retention for patients expected on treatment by APR 2016, PEPFAR DRC will achieve 80% saturation in the Kinshasa Saturation Cluster (7 HZs) as well as the Lubumbashi Saturation Cluster (10 HZs). The number of PLHIVs presumed living in the cluster was calculated by multiplying the provincial level prevalence (1.5% for Lubumbashi and 1.6% for Kinshasa) and the estimated population in the health zones in the cluster. In Lubumbashi, where a significant number of PLHIVs come to the city from rural areas to receive care and support services, a factor of 25% was added to the saturation level to account for this movement. Targets for HIV testing show a 74% increase over FY16 targets, reflecting APR 15 yield and entry point breakdown. FY16 Q1 results suggest that FY16 testing targets were significantly underestimated.

PEPFAR DRC will continue to build upon ACT achievements made in FY16, initiating 2,183 children (<15 years old) living with HIV/AIDS on treatment, giving a total of 8500 children on treatment by the end of FY17. This represents an increase of 290% from FY15.

To reach FY17 targets, PEPFAR DRC and its IP's must continue to maximize all entry points in order to reach individuals at risk for TB , Key Populations, especially FSW & MSM, children and partners of HIV patients, OVC and other vulnerable populations, etc. PEPFAR DRC will build on the success of its PMTCT program, to enroll over 95% of HIV-positive pregnant women in care and treatment services through Option B+. As nascent key population programs continue to grow and mature, they will contribute increasingly to the identification and retention of key population clients receiving treatment services.

FY17 targets will build upon PEPFAR DRC achievements of FY16. FY18 targets for the two saturation clusters are set to maintain the achieved saturation by enrolling new patients to cover approximately 20% of patients who may be lost to follow-up.

Tracking treatment retention and loss to follow-up quarterly is critical to achieving 90-90-90 in scale up to saturation HZs by APR 2017; the PEPFAR team will work proactively with partners to address this at

the site and health zone level actively and expediently. The team will also regularly assess partner and cluster-level progress towards targets, and adjust targets and address performance issues with partners to ensure that overall cluster targets are met. New strategies implemented in FY16 and FY17, such as the PODI+ model (described further in Section 4.8), will help ensure the required improvement in treatment retention to 80%, in order for PEPFAR to reach its targets.

FY17 targets are based, as a starting point, on FY16 expected results (i.e. targets). As actual FY16 results become available in Q3 and APR 2016, site-level targets may require adjustment, even as cluster-level targets remain fixed.

In COP16 planning, the rationalization process between PEPFAR and Global Fund created significant data challenges, due to the transition of sites and patients (unique and duplicate) from Global Fund to PEPFAR and vice versa. Data challenges also stem from the quality of site-level data, concerns around double-counting in GF/PEPFAR co-located sites, and lack of concordance among the available data sources (for example, national and provincial PNLS data and Global Fund and PEPFAR partner data). PEPFAR DRC's notable opportunity in COP16, as a result of the PEPFAR/Global Fund rationalization, as well as the internal PEPFAR rationalization, will be clear leadership and coordination at the HZ level. Throughout FY17, each HZ partner will be responsible for building capacity for data quality and use at the site and HZ level, feeding up into the provincial and national data.

Another data limitation for COP16 involves the number of PLHIVs (denominator). In COP16, PEPFAR DRC aligned its figures to PNLS, adopting 1.5% prevalence in the old Katanga province (applied to Haut-Katanga and Lualaba), and 1.6% in Kinshasa. This alignment affected the saturation targets, decreasing the estimated saturation level in Lubumbashi by 32% and increasing the saturation level in Kinshasa by 34%. To account for patients from outside the urban cluster accessing services in Lubumbashi, a factor of 25% was added to the Lubumbashi saturation targets. During FY17, partners will collect patient origin data, especially in large hospitals and reference centers, in order to better understand and estimate the effect of this migration for services. To address data concerns, PEPFAR will support UNAIDS and the PNLS with specific funding to calculate improved PLHIV estimates based on the newly designated Provinces (26 vs 11) and at Health Zone level. After data collection at the Province and HZ levels, calculations will follow the UNAIDS Spectrum process. New estimates are expected in time to inform COP17 planning**.**

Program efficiencies will primarily be gained through the increased volume within the refined, limited geographical footprint. In COP16, the PEPFAR program will be concentrated in three (of 26 total) provinces. PEPFAR will work in a total of 47 HZs + 1 military cluster), as compared to 95 HZs in COP 14. While the number of patients supported by PEPFAR in total increases 130% (from 31,124 in APR 14 to 71,566 targeted in FY17.), new service delivery models will also lead to efficiencies in the future. However, in the start-up phase, these efficiencies will not be apparent.

Table 4.1.1 ART Targets in Scale-up Clusters for Epidemic Control						
SNU	**Total PLHIV**	**Expected current on ART (APR FY 16)**	**Additional patients required for 80% ART coverage**	**Target current on ART(APR FY17) *TX_CURR***	**Newly initiated (APR FY 17) *TX_NEW***	**ART Coverage (APR 17)**
Lubumbashi Saturation Cluster	30,345	22,778	1,498	24,541	6,054	80%
Kinshasa Saturation Cluster	20,543	8,500	7,934	16,355	9632	80%
Total	**50,889**	**31,278**	**9,432**	**40,896**	**15,686**	**80%**

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts*			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY17)**	**Identified Positive (APR FY17)**	**Newly initiated (APR FY 17) *TX_NEW***
Adults			
TB Patients	***TB_STAT: 5,861***	***TB_STAT_POS: 839***	**TB_ART: *755***
Pregnant Women	***PMTCT_STAT (100,904)***	**PMTCT_STAT_POS (Newly ID'd) 1,386**	**PMTCT_ART (New) 1,502**
Other priority (KP, PP and General population	**HTC_TST (403,552)**	**13,751**	**12,363**
Pediatrics			
HIV-exposed Infants	***PMTCT_EID : 1,820***	**29**	**28**
Other pediatrics	**HTC_TST (34,716)**	**1,163**	**1,047**

* DOD data not included

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
[Specify target populations for focus] *Indicator Codes include* 1. PP_PREV - Militaries Miners - Trucker - AGYW - Men - Clients of FSWs	No size estimation done		PP_PREV: Militaries 46,325 Others 7,500 Total 53,825
2. KP_PREV. - FSW - MSM			FSW: 11,829 MSM: 3,300
Total			**76,454**

Table 4.1.5 Targets for OVC and Linkages to HIV Services		
Cluster	**Target # of active OVC (FY16 Target) OVC_SERV**	**Target # of active OVC (FY17 Target) OVC_SERV**
Lubumbashi Saturation Cluster	11,252	13,708
Kinshasa Saturation Cluster	19,671	20,138
Kinshasa Sustained Cluster	0	812
Haut-Katanga Sustained Cluster	0	0
Lualaba Sustained Cluster	0	0
Military		2,891
Total	32,277	37,548

4.2 Priority and key population prevention

Key Populations

Information about key populations in DRC is limited, particularly for MSM, transgender persons (TG) and Sex Workers (SW). PEPFAR is currently doing size estimations and mapping of key populations in Kinshasa, Haut-Katanga, and Lualaba. Existing data include a 2013 Integrated Biological and Behavioral Survey (IBBS) that indicated 6.9% of FSWs were HIV positive. The same report revealed that 69% of FSWs reported condom use at last sex with a paying sex partner and 36.2% with a non-paying sex partner. A study conducted in Kinshasa in 2011 found that 17.9% of MSM are HIV positive and only 15.3% surveyed used a condom during their most recent sexual encounter.

In FY14, PEPFAR DRC reached 1,850 MSM and transgender people and 16,689 FSWs through at least one evidence-based HIV prevention intervention. Comprehensive prevention, care, and treatment services are delivered through a limited number of outreach and key population-friendly facilities in Kinshasa and Katanga. With widespread stigma and discrimination toward key populations limiting their access to HIV services, PEPFAR DRC recognizes the need to increase focus on these high-risk populations and expand accessible and friendly service coverage in order to achieve epidemic control. In FY17, PEPFAR DRC will scale up existing interventions in Kinshasa and Katanga. Innovative interventions, such as peer-driven recruitment, will be intensified to rapidly increase the number of MSM and FSW reached. Mobile

strategies for HIV testing and counseling at or near hotspots will be strengthened and expanded. PEPFAR DRC will prioritize the continuum of care to ensure that HIV positive clients access care, support, and treatment services.

The clinical cascade analysis for key populations indicates significant loss between numbers reached and numbers tested, an important drop between tested positive and enrolled on treatment, as well as considerable attrition rates. To address these gaps, and drawing from lessons learned from SIMS visits, PEPFAR will strive for a greater mix and variety of HTC service delivery models, including mobile, community, and home-based services, instead of facility-based only. PEPFAR DRC is aiming to almost double KP Prevention results from 15,000 (FY16) to 25,000 (FY17). The DRC team will emphasize high yield approaches of enrolling hard-to-reach populations such as MSM and TG through the expansion of a peer-led incentives model.

For all key populations, PEPFAR will continue to offer the core package of services which include the promotion and distribution of condoms (male and female); and condom-compatible lubricant; STI screening and treatment; HIV counseling and testing with a focus on index-testing and linkage to ART; TB screening and treatment referral; STI screening and treatment; peer education and outreach; risk reduction interventions; violence prevention and care. GDRC will begin implementing the WHO directives for the Test and Start approach in 2016 and PEPFAR will ensure this extends to key populations. In select pilot areas, HIV-negative KP will be offered combined prevention counseling services including pre-exposure prophylaxis (PrEP). PEPFAR will increase and monitor adherence for key populations on ART and PrEP through trained peer outreach workers and support groups, and will increase the monitoring of viral load suppression for ART clients where laboratory services are available.

DRC plans to increase training and support to health providers to facilitate the integration of services for key populations in routine clinical services. This will include sensitization training of health care providers to reduce stigma and discrimination, other structural interventions (e.g., conducive opening hours, display of patients' rights posters and other materials), and monitoring the delivery of non-discriminatory HIV and health care services at PEPFAR-supported sites. Community services will be linked to the clinical platform using skilled peer educators who will promote HTC, early diagnosis and treatment of STIs, condom use, Positive Health, Dignity and Prevention (PHDP) initiatives, and linkages to care and retention on treatment. Linkage of positive KP instead of simple referrals will be a focus for PEPFAR DRC in FY17. As PEPFAR moves towards the expansion of the PODI+ community ART service delivery model (see Section 4.8), efforts will intentionally aim to ensure these facilities are KP-sensitive as the program targets the integration of KP friendly services into the PEPFAR supported clinical platform.

Stigma and discrimination remain significant hurdles, especially for identifying and reaching MSM and TG. In preparation of COP16, meetings with CSO underlined the need for structural interventions, such as targeted reinforcement of the justice and law enforcement systems in DRC (judges, lawyers, police, etc.), in other to sensitize them towards the issue of the respect for the human rights of key and

vulnerable populations. As a direct result of these discussions, PEPFAR DRC will provide funding through the Ambassador's Small Grants program to the National Network of HIV and TB NGOs, to build their capacity to advocate for structural interventions that will reduce the impact of stigma and discrimination, and foster an enabling environment for key populations, as well as all PLHIV, to access health services, and educate them about their human rights. This funding will also support civil society, especially MSM and FSW groups, to monitor cases of human rights violations and the ongoing debate in the DRC parliament on the law criminalizing homosexuality.

Priority Populations & Vulnerable Populations

Priority populations for PEPFAR DRC include uniformed personnel, truckers, miners, clients of sex workers, steady partners of sex workers, OVC, and adolescent girls and young women, because of the high prevalence rates for HIV among these populations and associated risky behavior and vulnerabilities, (ProVic, Key Pop Study, Kinshasa, 2013-2014). The NSP 2014-2017 identifies youth as a priority population, and the recent DHS (2014) indicates that young women ages 15-24 years are 2.5 times more at risk of contracting HIV than their male peers. This vulnerability has been partially attributed to early onset of sex, the rate of unprotected sex, and the high occurrence of gender based violence against females in this age bracket. For FY17, PEPFAR DRC is adding men in the work place in scale-up zones as a priority population, due to their specific vulnerabilities and late access to service.

The National HIV/AIDS Strategic Plan (NSP 2014-2017) notes (from the 2013 IBBS) a significant reduction of HIV prevalence among mobile populations: 6% in 2005 to 1.8% in 2012 among miners and 5.3% in 2005 to 1.2% in 2012 among truckers. The 2013 military HIV sero prevalence and behavioral survey indicated a general prevalence of 3.5 % among military personnel. Despite the reductions in some groups, HIV prevalence among these populations remains higher than the national average.

In COP16 PEPFAR DRC plans to scale up interventions among Priority and Other Vulnerable Populations (OVPs).

In the 2016 COP, PEPFAR DRC will coordinate with the GDRC and other partners to develop a national strategy and guidelines for key populations and OVPs, to address gaps in epidemiological and behavioral data, particularly for MSM, FSW and miners.

4.3 VMMC (Not Applicable for DRC)

4.4 PMTCT

In 2013, PEPFAR, in collaboration with the GDRC, UNICEF, WHO and UNAIDS, developed and initiated DRC's strategy for phasing in Option B+, starting with six HZs in the Lubumbashi area of Katanga province. After one year, the program was assessed and the decision was made to expand Option B+ to all PEPFAR-supported HZs in Katanga, Kinshasa, and Orientale by March 2015. The rollout of this

expansion underscored challenges surrounding the management and provision of drugs (e.g., coordination of donors) and the PNLS-led rationalization process is an attempt to resolve some of these issues.

Option B+ is still in the early stages of implementation in most sites; therefore PEPFAR DRC's PMTCT costs have risen due to increased training needs of health care providers and community workers and increased procurement of commodities (mostly ARVs). Concurrent with the roll out of Option B+, DRC switched from AZT to Tenofovir for pregnant women. The PEPFAR DRC team and its supply chain IPs are working quickly with the GDRC and the Global Fund to ensure that existing stocks of AZT are depleted and that a smooth transition takes place. On March 23, 2016, DRC issued a memorandum for the full implementation of TDF-based regimen throughout the country.

In COP16, PEPFAR DRC will continue scaling up PMTCT using Option B+ in the Scale-up to Saturation HZs. The integrated package of PMTCT services includes: HTC/PITC; ART (adult and pediatric); Cotrimoxazole; nevirapine prophylaxis for infants; comprehensive family planning; TB and opportunistic infection screening and referral; GBV screening and referral where services exist; lab sample (e.g., Early Infant Diagnosis [EID], viral load [VL]) collection, transportation and analysis; and linkages to community, OVC, malaria, nutrition and Water, Sanitation, Hygiene (WASH) services. PEPFAR DRC will focus on training, coaching and mentoring health care providers to ensure that they are equipped to provide adequate ART services to all HIV positive pregnant women, transition women currently on prophylaxis to ART, promote adherence and retention, and reduce loss to follow-up.

To help reduce loss to follow-up in the scale-up to saturation HZs, PEPFAR DRC will strengthen the network of mentor-mothers and health center and community peer educators. Where they exist, support groups will be reinforced to enable them to promote adherence with individual HIV-positive pregnant women (and other PLHIV) in their community. In addition to these community activities, the use of appointment registers to track patients and appointment reminders by phone (call & SMS) or home visits by peer educators or community health workers will be promoted.

The PEPFAR DRC team will facilitate collaboration between clinical implementing partners focused on key and other vulnerable populations to ensure delivery of PMTCT services at the nearest location to these populations.

The National Reference Laboratory in Kinshasa is the main provider of early infant diagnosis for HIV using HIV DNA PCR on Dried Blood Spot (DBS) in the DRC. At the same time, PEPFAR DRC has negotiated with two other labs, Kinshasa Dreams and MSF, to expand EID testing opportunities. As PMTCT coverage expands, improving the retention of mother-infant pairs is a priority. Initial SIMS visits have shown that improvement is needed in the timely return of test results to mother-infant pairs. PEPFAR DRC, in collaboration with other relevant national stakeholders, will continue to provide support to improve the sample transportation network.

To reduce the turnaround time for receiving results, PEPFAR DRC and the Global Fund recently invested in a provincial laboratory in Lubumbashi to perform EID and viral load. The laboratory has been fully

operational since July 2015. A sample transportation network (EID and VL testing), a Laboratory Information System (LIS), and a Quality Assurance (QA) system are in place to ensure the scale up of VL testing in the province.

4.5 HTC

To reach epidemic control in Saturation HZs, PEPFAR DRC will maximize testing of priority populations and thus identify the maximum number of HIV-positive individuals to link to care, support, and treatment services while also linking HIV negative clients to prevention services. PEPFAR objective is to test 884,011 people in FY17 (232,458 through PMTCT).

The GDRC has developed appropriate guidelines and conducted trainings necessary to fully implement PITC. Based on APR trends and national results from previous years, which show a relatively high contribution of PITC to the number of HIV-positive individuals identified, PEPFAR DRC will increase its focus on PITC and HTC outreach focused on key populations and other vulnerable populations in the scale-up to Saturation HZs. Specifically, PEPFAR DRC's HTC service delivery package for priority populations and geographical areas will include:

PITC targeting pregnant women and their families, hospitalized patients with clinical symptomology, TB patients and their families, at risk children (i.e., malnourished children, OVC, and children born to HIV-positive adults) in clinical settings.

To support the Accelerating Children's HIV/AIDS Treatment Initiative (ACT), standard operating practices have been developed to scale up testing at all entry points and focus support on the highest yield entry points, resulting in over 80% of OVC and family members being tested for HIV. For all patients identified, PEPFAR DRC will ensure linkages to treatment services.

PEPFAR DRC will continue to engage the community in HTC activities through community-based civil society channels such as PLHIV support groups. Such groups provide feedback on the quality of HTC services and participate as lay counselors and in community-based activities.

An issue noted during SIMS visits is the weak implementation of HTC quality assurance (QA)/quality improvement (QI) at the site level. PEPFAR DRC will work with Implementing Partners (IPs), service providers and the MOH to put in place quality monitoring and evaluation mechanisms and evidence-based QA/QI practices, including effective and efficient site level HIV/AIDS proficiency testing. PEPFAR DRC will also provide support for re-testing of positives before starting treatment, as DRC will move quickly on the "Test and Start" approach before October 2016.

4.6 Facility and Community-Based Care and Support

In COP16, PEPFAR will continue to support a standard package of care and support services in priority and sustained health zones, including TB screening and referral, provision of cotrimoxazol, viral load,

positive health, dignity and prevention services. In the Scale-up to Saturation HZs, PEPFAR DRC will focus on the 4+1 strategy as the core platform for care and support. This strategy includes the four universal interventions: regular clinical monitoring, CD4 count and/or viral load if possible; screening for active TB or intensified case finding, with referral for diagnosis and treatment as appropriate; Cotrimoxazole prophylaxis; and evidence-based interventions to optimize retention in care and adherence to ART that address local gaps and barriers; plus positive health, dignity and prevention as the "+1".

Priorities for improving linkages and retention in care include: supporting the GDRC to develop national care and support guidelines and standards; implementing the standardized care package defined by PEPFAR DRC in the absence of a national package; increasing collaboration between GDRC's HIV/AIDS and TB control programs; and expanding the Nutrition, Assessment, Counseling and Support (NACS) model within the Option B+ platform. NACS will be scaled up at the facility level and piloted in selected communities near high-yield facilities. A strong focus will be placed on QA/QI and local capacity building and leadership in adult and pediatric care and treatment.

Since FY12, PEPFAR DRC has implemented several innovative approaches, such as mentor-mothers for PMTCT retention and support, quality improvement of care and support, and monitoring facility progress towards PEPFAR-defined standards of care. These initiatives are being assessed, and will be expanded to increase quality and coverage of services. Successful strategies and lessons learned will be used to inform a national strategy for care and support. PEPFAR DRC is committed to supporting the inclusion of QI for community and facility-based care and support in the national M&E system, including support for designing relevant tools.

SIMS data revealed a need for systems and procedures for retention in care and treatment services, including a stronger referral and counter-referral system. PEPFAR DRC will support the most appropriate model of care and support given contextual factors such as patient barriers to retention in care, geographic barriers to accessing the health system, and regulatory or logistical constraints to ART delivery.

To improve care and support, PEPFAR DRC will work with the PNLS to expand and formalize the ongoing decentralization of ARV prescribing authority from the chief HZ physician to clinic staff, task shifting to lay health worker cadres, and multi month medication refills for stable patients.

To address the increasing numbers of patients at facilities following the expansion of ART eligibility criteria with the roll out of Test and Start and the continuation of Option B+, PEPFAR DRC will be expanding community-based services that will help to alleviate the burden of increased HIV patients at high volume sites, and allow for better patient monitoring and retention. Specifically, PEPFAR will expand the possibility to access ARVs to stable patients in their community by replicating the successful experience of Doctors Without Borders with Community ARV distribution posts (PODI). The approach proved to be rewarding in many regards: saving time for both the patient and the provider, saving cost and increasing adherence. PEPFAR is proposing an improved version called "PODI+" which will provide

ARV and counseling to stable patients on a quarterly basis while clinic visits will be indicated twice a year. In PODI+ models, essential tasks such as weighing and symptom-based health assessments will be provided by a trained peer educator or expert client who acts as the club facilitator. Assessments are captured in patient records and monitored by clinic staff via a reporting linkage between the club facilitator and the clinic. Clients of the PODI+ will see a nurse twice a year – once for blood tests and then two months later for their annual clinical check-up. Any client reporting symptoms is referred back to the main ART clinic for prioritized assessment by a nurse.

In COP16, PEPFAR will aim to install ten PODIs that will be linked to high volume clinical sites (>200 patients on ART) through a robust referral-counter referral system that will ensure client tracking and data accountability.

DRC Strategies for improving Retention

Current retention rate is 73% in FY16. We plan to increase the retention rate from 73% to 80% for COP16. We intend to implement and/or reinforce the following strategies:

A. New service delivery models:
    1. Multi-month medications refill for stable patients including :
        - Fast drug refill at the health facility
        - PODI model: MSF experience already showed 91% of retention at 12th month and 85% at 24th month. Therefore we expect to leverage on this experience to improve our retention through PODI+
    2. Decentralized services through community platforms and task shifting including:
        - Facility and community-based support groups: mentor-mothers, adolescent support groups, OVC platforms/interventions, treatment adherence clubs, to encourage retention and track clients who have defaulted, support adherence, etc.

B. Improve strategic information
    1. Electronic tracking/monitoring tools for high volume sites (Tier.net, EDT,…) facilitating timely and early identification of potential defaulters and take immediate actions through community peers/health care providers
    2. Quality improvement approaches

C. Environment
    1. Collaboration with civil society PLWHIV networks to reduce stigma and discrimination issues (CSO small grants)
    2. Ensure community engagement through education, information and communication
    3. Address user fees issues by:
        - Investigating the problem
        - Advocating to GDRC to address user fees by increasing subsidies to public facilities
        - Monitor sites and ensure (informal) extra fees are not being charged; educate and empower patients on their rights

4. The gender analysis and ongoing QI process have identified structural barriers. Approaches to address these have been included in the SDS. In addition, a survey through focus group discussions with PLHIV to further identify verify/identify barriers will be carried out and addressed accordingly.

D. Supply chain
   1. Improve long-term forecasting and efficient distribution of ARVs and other commodities

4.7 TB/HIV

The HIV prevalence among registered TB patients is approximately 14% in the DRC (WHO, Global Tuberculosis Report, 2014), or nearly 12 times the prevalence in the general population. Despite this, only 69% of registered TB patients in PEPFAR zones were tested for HIV in FY15, and only 31% of HIV-positive TB patients in PEPFAR zones were on ART during TB treatment. In order to improve these numbers, PEPFAR DRC, in collaboration with the National Tuberculosis Program (PNLT), will 1) expand HIV testing among TB patients; 2) increase initiation of ART among co-infected patients and expand HIV care services within TB clinics; 3) decrease TB-related morbidity and mortality among PLHIV by improving TB screening and linkages to TB treatment and prevention services; and 4) support TB/HIV coordination and TB/HIV care and treatment integration to ensure linkages and retention. These activities will align with the USG's 2015-2019 Global TB Strategy, and will remain core PEPFAR activities.

A number of TB/HIV challenges have been documented through SIMS data: many HIV patients are not routinely screened for TB, most clinics do not have TB infection control plans, isoniazid preventative therapy (IPT) is not regularly provided, and TB treatment outcomes are not tracked in HIV registers. Additionally, the recent PEPFAR gender analysis showed that administrative fees often prevent women from accessing TB and HIV health services that are supposed to be free. In order to address these issues, PEPFAR DRC will provide training in TB infection control and support the development of TB infection control plans, and will make sure TB screening tools are available at all supported sites. Partners will report on custom indicators on IPT and tracking of TB treatment outcomes. PEPFAR DRC will also ensure that TB/HIV clinics it supports are not charging the fees that are barriers to access for many women.

The TB/HIV service delivery package in scale-up health zones will include (1) intensified HIV testing among TB patients; (2) improved ART initiation among co-infected patients; (3) intensified TB case-finding and linkages to TB treatment among PLHIV; (4) tracking of TB treatment outcomes in PLHIV; (5) expanded TB infection control measures; (6) IPT for all PLHIV without confirmed active TB; and (7) community-based services including adherence support and socioeconomic and prevention services. In addition, PEPFAR DRC will continue to provide technical assistance to the national and peripheral laboratories and support the scale-up of Gene Expert to improve case finding and sample quality.

Coordination between the PNLT and PNLS, including the creation of integrated TB/HIV forms and registers, will also be a priority.

According to national treatment protocols, co-infected patients are already eligible for test and start. But many TB clinics do not offer ART on-site, so patients must be referred to HIV clinics to begin treatment, and they are often lost to follow-up. Regardless of where ART is initiated, co-infected patients have to be referred from TB clinics to HIV clinics at the end of their TB treatment, and ART is often interrupted at this point. To address these issues, PEPFAR DRC will support clinics that provide both TB and HIV services, and will strengthen referral systems through clear documentation and counter-referrals.

All HIV patients will be screened for TB at every clinical appointment. For patients who have clinical appointments less than four times a year, community groups will be used to ensure that they are screened for TB at least once every three months. Communities platforms will help carry out contact tracing of co-infected patients to identify more HIV and TB patients among their family members. Community health workers (including former TB patients) will also support hard-to-reach populations and patients needing to travel long distances to access TB or HIV services.

The most common reason for failure to test TB patients is a lack of HIV tests at TB clinics. PEPFAR DRC will work to ensure the availability of HIV tests and ARVs at TB clinics.

4.8 Adult HIV Treatment

DRC has low coverage of adult treatment. In 2014, PNLS reported 390,000 adults living with HIV, of whom 101,324 (26%) were on ART. GDRC is planning to move quickly to adopt and implement the new WHO guidelines on test and treat. The training of providers in 354 health zones is planned for spring 2016. A 'note technique' and information bulletin will be shared to guide providers on implementation. This will increase the number of adults eligible for ART. PEPFAR DRC, along with other donors, continue to advocate with GDRC to update its policy on task shifting to allow full implementation of the new ART guidelines, including allowing nurses to initiate and monitor ART.
Upon implementation of Test and Start by GDRC in June 2016, PEPFAR partners will aggressively identify and initiate on treatment all identified pre-ART patients by the end of FY 2016. PEPFAR DRC's rapid roll-out of Test and Start in FY 2016 will be implemented in both saturation and sustained support health zones.

The PEPFAR DRC ART service delivery package includes: HTC/PITC in high yield entry points (e.g., TB, inpatients, FSW, MSM); ART according to updated national guidelines; Cotrimoxazole prophylaxis; prevention, diagnosis and management of TB (TB screening, Infection Control, IPT); implementation of Quality Measure/Quality Indicator (QM/QI) initiatives at the facility/community level; adherence support; enhanced linkage and retention along the care cascade; lab monitoring on ART (e.g., viral load); training and mentorship; and regular supportive supervision. This package has been defined in alignment with

PEPFAR's core/near-core/non-core framework. In addition to PODI approach, PEPFAR foresees adoption of optimized service delivery models including categorization of patients and tailoring services in:

- Initiating patients
- Stable patients (those with undetectable VL or based on simple clinical criteria: adherent and regular to clinic visits without IOs for 12 months): Clinic visits every 6 months ARV, CTX pharmacy pick-up every 3 months (or PODI), Annual VL testing, Annual creatinine for patients on TDF based-regimen, Annual Hemoglobin for patients on AZT based regimen
- Patients presenting with advanced disease or failing ART: close monitoring, clinic visits each month to reinforce adherence counseling and monitor OIs, VL after 3 months following the ART failure and switch to second line ART if failure confirmed by VL done at 3 months. Then VL after 6 months of second line and then Annually VL testing. In case of undetectable VL, then monitor as stable patient

The results from SIMS visits have underlined a lack of documentation of procedures, poor adherence support, and weak linkages to community services. Partners are addressing these issues, as strong linkages to care and support systems are critical to retention and achieving epidemic control. In FY17, PEPFAR DRC will strengthen efforts to work with Community Service Organizations (CSOs), Faith-Based Organizations (FBOs), and Non-Governmental Organizations (NGOs), Mentor-Mothers, expert patients, and support groups in order to:

- Link priority populations to care and treatment services, ensuring that all clients have access to the full continuum of care;
- Promote adherence and retention in care and treatment services – working in close collaboration with health facilities to ensure complete bidirectional (facility-community) referrals and identifying a standardized system for client follow-up and tracking to ensure clients are not lost during the referral process;
- Support tracking of defaulters and clients lost to follow up, escort clients to services as necessary and provide feedback to facilities;
- Strengthen the package of care and support services provided at the community level, including: PHDP services; support for adherence to Cotrimoxazole and TB preventive therapy; identification of opportunistic infections (OIs) and side effects; NACS and WASH; psychosocial support services; and identifying opportunities to leverage complementary services not provided by the program (e.g., access to condoms, FP and MCH services, food distribution programs, mosquito nets); and
- Conduct peer support group meetings (in community or at facility) and provide educational and counseling services.

- Priority populations such as pediatrics, AGYW, and key populations will be reached using appropriate and specific strategies (refer to related sections).

4.9 Pediatric Treatment

DRC has low pediatric treatment coverage. In 2014, 66,000 children were living with HIV, but only 8,523 (13%) were enrolled in treatment. DRC is planning to adopt the WHO test and treat guidelines including universal treatment for children < 15 years living with HIV regardless of CD4 count.

The ACT initiative is aiming to double the number of children on treatment from the 2013 baseline. ACT will mainly be focused on six out of seven pillars to reach the target (policy; community engagement; case identification; linkage to care and treatment; initiation, adherence and retention; M&E), moreover, DRC is working to ensure that data is collected so that the highest yielding entry points are known and targeted through intensified case identification with increased entry points testing. ACT activities are complementary to COP.

OVC and Care/Tx partners will improve linkages/referrals between community and facility services through regular ACT Coordination meetings, led by the PNLS. DRC is one of the ten ACT countries and has a goal of expanding pediatric treatment from 3,200 (FY14) to 4,899 (FY15) and 7,573 (FY16). During this and future COP cycles, PEPFAR DRC will continue to scale up pediatric treatment in high-yield locations to contribute to epidemic control. Case-finding methods such as the family-centered approach are being intensified among children born to HIV-positive adults, malnourished children, inpatients, OVC, children in TB clinics, and HIV exposed infants through EID and children for positive clients.

The pediatric treatment service delivery package includes: EID; HTC of children for early identification; PITC and disclosure for children and adolescents; Cotrimoxazole and Neviraprine prophylaxis; prevention, diagnosis and management of TB (i.e., TB screening, IC, IPT); ART for all < 15 children; adherence support and enhancing linkages and retention along the care cascade; lab monitoring on ART (e.g. VL); and training, mentorship and regular supportive supervision. This package has been defined in alignment with PEPFAR's core/near-core/non-core framework.

To increase pediatric enrollment on treatment, adherence, and retention, PEPFAR DRC will strengthen the community's role in ensuring linkages between facility and community-based services. As with adult treatment, working with CSO/FBO/NGO organizations and providing support through Mentor-Mothers, expert patients, and other support groups, PEPFAR DRC will focus on:

- Identifying and enrolling OVC into relevant social services;

- Supporting activities that promote adherence to and retention in care and treatment services, working in close collaboration with health facilities to ensure bidirectional (facility-community) referrals and identifying a standardized system for following up and tracking clients to ensure they are not lost during the referral process;
- Tracking defaulter clients and clients lost to follow up, escorting clients to services as necessary, and providing vital information about clients' whereabouts to facility staff so they can follow up;
- Strengthening package of care and support services provided at the community level including support for adherence to Cotrimoxazole and TB preventive therapy; identifying OI side effects and referring to facility; NACS; and psychosocial support services.
- Encouraging GDRC to update its official policy on task shifting to align with the WHO guidelines, which allow a nurse to lead the initiation and monitoring of ART.
- Advocating to government and public sectors to support children living with HIV and OVC.

SIMS visits have highlighted a lack of support for adolescents with HIV at health facilities. PEPFAR DRC will address this weakness through the implementation of ACT activities, which will help to collect data on adolescents, particularly AGYW, and to develop targeted strategies and activities to meet their specific needs, such as creating more adolescent-friendly clinics.

As with adult treatment, supply chain concerns include stock outs of pediatric ARVs, long and challenging customs processes, and partners' limited storage space. As noted in Section 4.8, the PEPFAR DRC team is negotiating with the GDRC to ensure the release of commodities from Customs in a timelier manner and to obtain adequate storage space by using provincial warehouses to obtain adequate storage space.

4.10 OVC

The National HIV AIDS Strategic Plan 2014-2017 (NSP 2014-2017) estimates that there are 391,053 orphans of one or both parents due to HIV/AIDS in the DRC. Children under the age of 15 frequently experience violence, sexual abuse, and economic hardship, and children living without parents (especially girls) are at higher risk of both maltreatment and HIV infection from sexual abuse and/or exploitation. Child marriage rates are also high: in 2013, 21.3% of girls aged 15-19, and 6.5% of girls under 15 were estimated to be married or living with a partner. Supporting children and households affected by HIV is an essential step in achieving epidemic control.

In FY17, PEPFAR DRC will focus on enhancing services and linkages for orphans and vulnerable children (OVC) through a multi-component approach linking OVC services to clinical services. OVC programming will clearly support the PEPFAR continuum of care in by serving a sub-set of critically vulnerable children and their families in saturation HZs served by PEPFAR clinical programs, as well as

in two sustained health zones where pediatric hospitals are located. In these HZs, PEPFAR will target 1) HIV-affected infants, children and adolescents and their families; 2) HIV un-infected adolescents accessing ANC services; and 3) children and adolescents who are members of key population groups.

PEPFAR's package of OVC services will include 1) encouraging testing among OVC and their caregivers and facilitating mobile testing alongside other OVC activities; 2) referring participating families for case management and other HIV services for which they are eligible; 3) child protection activities; 4) economic strengthening activities; and 5) ensuring continued access to education for OVCs. These services will help mitigate the impact of HIV and AIDS on households and improve the behavior of parents and caregivers. Additionally, in several Kinshasa sustained support health zones with a high yield of pediatric patients, the program will ensure that OVCs benefit from an improved referral system.

Facility-based implementing partners will use a tool to assess vulnerability and evaluation criteria to identify children eligible for OVC support, and will play an important role in providing OVC and their host families a minimum package of support in a timely manner. OVC service providers will also receive referrals of eligible families from clinical partners, especially those involved in PMTCT and pediatric care and treatment.

5.0 Program Activities in Sustained Support Locations and Population

5.1 Maintenance package of services in sustained support areas and populations

In the 30 HZs classified for Sustained support by PEPFAR, the program will continue to ensure access to the government's basic package of facility-based prevention, treatment and follow up services for pregnant women, families of PLHIV, children, and other high risk groups. In sites with insufficient positivity yield (HTC less than 12, PMTCT less than 8) PEPFAR will de-prioritize support. In sites with fewer than 5 patients on treatment, where feasible, ART patients will be transferred to higher volume and higher quality sites. In sites that we cannot transfer, as a rule, no demand creation will be promoted and activities will be reduced at minimum both in scope and in scale in these areas. No patient will be denied treatment; if a pregnant woman at ANC or another client from any clinical entry point requests HIV testing or presents with an OI (e.g., STI, TB), testing and treatment will be provided as needed.

In sites with sufficient positivity yield (HTC more than 12, PMTCT more than 8) and with 5 or more patients on treatment, a maintenance package of services will be implemented. In these sites, current patients on treatment will be maintained in care and treatment services. PEPFAR will fund routine testing of pregnant women in sites whose yield is eight or more. As the DRC PMTCT guideline requires testing for all pregnant women at ANC, PEPFAR will engage in dialogue with the MOH for the GDRC to procure Rapid Test Kits (RTK) for sites that will no longer be supported by PEPFAR. The maintenance package will also include ART for adults and infants, infant Nevirapine prophylaxis, Cotrimoxazole

provision, PHDP including condoms, routine clinic visits, screening for TB, INH prophylaxis, screening for STI, adherence and retention activities, routine lab monitoring including viral load (VL) and EID.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts

Maintenance Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites	142,742	132,106	-8.05%
HTC (only maintenance ART sites in FY 16)	107,570	153,951	30.13%
*Current on care (not yet initiated on ART)	739	0,00	-100.00%
Current on ART	**24,403**	26,020	6.20%
OVC	0,00	812	100.00%

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

While GDRC contributes approximately 13% of institutional expenses to the national HIV/AIDS response (NASA 2014), PEPFAR and the Global Fund are the most important supporters in DRC for HIV/AIDS service delivery. A tripartite 'rationalization' agreement signed with the Global Fund and the MOH by the US Ambassador to DRC (October 2015) clarified roles in terms of responsibility for supporting HZs. This agreement led to a reduction in the number of PEPFAR intervention provinces from seven to three; the number of intervention HZs from 97 to 47 + 1 military, while aiming to reach more patients (71,756). In terms of service delivery, the rationalization has meant the transition of activities from PEPFAR to the Global Fund in Ituri, Tshopo, haut Lomami and Tanganyika provinces. At the same time, PEPFAR DRC is taking over previously Global Fund-supported sites in focus geographical clusters in Haut Katanga and Lualaba (all the health zones), Kinshasa (most of the previous collocated heath zones), and will implement recent WHO recommendations that include test and start for all patients by increasing investments for ARVs, lab, VL and other commodities.

Table 5.2.1 Impact of transitioning Global Fund patients in and out of PEPFAR, retention rates, final targets and net gains for COP 2016

Patients	FY'15 APR	TX_CURR FY'16 Target	TX_CURR FY'17 Target	TX New FY17	Net New FY'16 to FY`17
Transferred from USG to Global Fund		-	0		-14,285
PEPFAR Saturation and Sustained	47,335	69,109 (includes 6,209 from GF)	66,726 (Excludes military targets of 4,840 Total: 71,756)	23618	16,270**

PEPFAR DRC will also transition ACT Initiative achievements into the current program under the leadership of the PNLS. The OVC program will be scaled up in key saturation clusters while in maintenance clusters, central support will aim to enable the environment for risk reduction. The transition means that PEPFAR DRC will accelerate the achievement of epidemic control in the right places (high burden provinces of Kinshasa and Haut Katanga). The transition of HZ between PEPFAR DRC agencies (internal rationalization) was completed in March 2016. The PNLS led rationalization between GF and PEPFAR is ongoing, with planned completion by the end of 2016.

At the end of FY 18 as the saving groups will mature and local child protection committee will be strengthened, PEPFAR/DRC will transition OVCs activities in Kinshasa sustained support health zones to GDRC and local organizations. Community-based organizations will be accompanied to map out and leverage existing investments within targeted communities such as UNICEF's protected communities programs and efforts will be spent to strengthen local social workers to improve referrals and access to existing social programs. For some categories, small business skills will be enhanced and PEPFAR partners will provide key inputs to support businesses and income generating activities.

6.0 SBOR / Health System Investments

The SBOR analysis for COP16 included a review of the Sustainability Index results, Expenditure Analysis data, partner and government health system analyses, and a program data review. The review of critical system weaknesses that pose the greatest obstacle to achieving a higher level of service quality, patient access to services, ultimately to improving HIV-related outcomes, were the focus of the DRC team's discussion internally and with external stakeholders. The team also discussed with external stakeholders, to identify the health and community systems investments that are critical for improving the identification of PLHIV, access and uptake of ART services, and increasing retention.

The process led to the selection of three priority program gaps for DRC: 1) Low number of patients identified positive that are put on treatment; 2) TB-HIV Co-infection and the insufficient integration of HIV and TB intervention all levels; and 3) Low Viral Load testing and monitoring of viral suppression.

The key systemic weaknesses that underscore these program gaps include 1) a fractured and unresponsive supply chain, 2) weak laboratory and sample transport systems, 3) slow and incomplete information management systems, and 4) the lack of institutionalized quality assurance systems across all areas of the national response and 5) weak community networks and links with clinical services.

The following tables represent the key system barriers that specific activities will address, and the expected outcomes after a three year period, along with the amount budgeted by PEPFAR DRC to conduct the activity.

Table 6.1.1 Key Programmatic Gap #1: Low Number of Patients that are Diagnosed Positive who are put on Treatment							
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Milestone**	**Proposed COP 16 Activity**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Partner**	**Relevant SID Element and Score (if applicable)**
Health System barriers Treatment guidelines not aligned to the last WHO directives, unclear task shifting approach, limited trained human resources, frequent commodity stock-outs	• 95% of PLHIV identified in PEPFAR-supported sites initiated on ART • All PEPFAR-supported sites implement Test and Start	Number of providers trained on test and start	Implement test and start (update policy, train providers)	OHSS PDTX HTXS PDCS HBHC	$50,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus	2. Policies and Governance (Yellow) 6. Service Delivery (yellow)
		Availability of ART security stock	Strengthen national supply chain system	OHSS	$1,350,000	GHSC-PSM, GHSC-TA	8. Commodity security and supply chain (Red)
			Procure ARVs, RTKs and other necessary commodities to allow for Test and Start in all PEPFAR-supported sites	HTXD PDTX	$14,212,193	GHSC-PSM, GHSC-TA	8. Commodity, security and supply chain (Red)
		Number of providers trained on post-test in PEPFAR	Strengthen providers capacity in post-test counseling (training/refresher,	PDTX HTXS PDCS HBHC	$75,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	7. HRH (Yellow) 6. Service Delivery (Yellow)

		supported facilities	clinical mentorship, supportive supervision, SOPs, …)				
		A well-functioning referral system implemented	Establish clear active referral system to treatment site mainly with mobile testing program to ensure continuum of care	PDTX, HTXS PDCS, HBHC	$100,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	6. Service Delivery (Yellow)
Socio-cultural economic barriers	• PEPFAR-supported health facilities and communities are user-friendly for PLHIV • Community and PLHIV sensitized on HIV treatment benefits in all PEPFAR-supported HZs	Strengthened human capacity resources to avoid stigma	Organize mass campaigns on HIV and HIV treatment benefits aiming to build stigma-free communities	PDCS HBHC	$249,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	3. Civil Society Engagement (Yellow) 6. Service Delivery (Yellow)
		Number of HCWs trained	Train providers on confidentiality and non-discrimination (PLHIV rights)	PDCS HBHC	$50,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	3. Civil Society Engagement (Yellow) 6. Service Delivery (yellow)
		Number of support groups strengthened	Reinforce peer psycho social support groups in all sites	PDCS HBHC HTXS	$45,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus	3. Civil Society Engagement (Yellow) 6. Service Delivery

							(Yellow)
Weak referral and counter-referral systems between health facility and community	• Improved patients tracking system for ART in all PEPFAR-supported HZs • Strengthened motivation system for CHW in all supported HZs • Improved Community management of ARV (PODI)	Number of PODI+ centers implemented	Establish 10 PODI+ centers in selected high volume sites in scale-up HZs	PDCS HBHC HTXS	$450,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	6. Service Delivery (Yellow)
		Tracking system tools implemented to monitor tracking system	Reinforce the tracking system for defaulters (registers, agenda for appointments…)	PDCS HBHC HTXS	$80,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	6. Service Delivery (Yellow)
		Referral system implemented	Organize active referral through peer navigators/peer educators/mentor mothers	PDCS HBHC HTXS	$120,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	6. Service Delivery (Yellow)
		HCWs fees motivated	Establish motivation system for Community Health Workers	PDCS HBHC HTXS	$85,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, IHAP	6. Service Delivery (Yellow)
TOTAL					**$16,156,193**		

Table 6.1.2 Key Programmatic Gap #2: Insufficient Integration of HIV and TB Interventions – All Levels							
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Milestone**	**Proposed COP 16 Activity**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Partner**	**Relevant SID Element and Score (if applicable)**
Insufficient coordination between HIV and TB programs at the national and provincial levels	• Production and distribution of joint HIV/TB tools and registers to ensure proper screening and diagnosis and tracking of treatment outcomes • Joint TB/HIV training and supervision plan at national and provincial levels •Functioning TB/HIV working groups at national and provincial levels to address issues	Number of facilities with TB/HIV tools Number of joint TB/HIV national and provincial supervision conducted Number of TB/HIV TWG meetings (documented)	Strengthen national and provincial TB-HIV platforms, including coordination and technical meetings	OHSS	$300,000	IHP-Katanga, IHAP, PROVIC-PLUS, ICAP, EGPAF, SANRU	Planning and Coordination Policies and governance (Yellow)
			Support joint TB/HIV training, supervision, and field visits at national and provincial levels	OHSS	$300,000	IHP-Katanga, IHAP, PROVIC-PLUS, ICAP, EGPAF, SANRU	Human Resources for Health (Yellow)

	including procurement						
Low percentage of TB patients being tested for HIV	• All TB diagnostic centers providing HIV testing •Availability of ART at TB diagnostic centers •Integrated TB/HIV community programs to support adherence to both regimens	Number of TB centers providing HIV testing and care and treatment	Increase referrals for HIV testing through community-based approaches	HVTB HBHC	$400,000	IHP-Katanga, IHAP, PROVIC-PLUS, ICAP, EGPAF, SANRU	Service Delivery (Yellow)
			Improve adherence for TB/HIV patients though community-based care and support services	HVTB, HBHC HTXS	$250,000	IHP-Katanga, IHAP, PROVIC-PLUS, ICAP, EGPAF, SANRU	Service Delivery (Yellow)
Insufficient TB prevention measures	• TB infection control plans in place at all PEPFAR-supported facilities • IPT integrated into TB/HIV activities	Number of facilities with TB IC plan Number of sites implementing IPT activities	Support development and implementation of TB infection control plans Support IPT programming workshop	OHSS HVTB HTXS	$100,000	IHP-Katanga, IHAP, PROVIC-PLUS, ICAP, EGPAF, SANRU	Service delivery (Yellow)

TOTAL		**$1,100,000**

Table 6.1.3 Key Programmatic Gap #3: Insufficient VL Requested and Performed for People on ART							
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Milestone**	**Proposed COP 16 Activity**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Partner**	**Relevant SID Element and Score (if applicable)**
Poor demand creation	• Increased VL tests requested by clinicians from PEPFAR supported sites • Patients are regularly informed on the need/importance of VL monitoring • Mass campaign conjointly organized with MOH and CSOs to involve people on ART in the VL monitoring	VL norms/algorithm and patients IEC tools (posters, pamphlets, etc) available in all PEPFAR treatment sites	Training of HCWs	HLAB OHSS PDCS	$140,000	ASM, ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, ASF/PSI	6. Service delivery (Yellow)
			Sensitization of patients	HLAB OHSS PDCS	$60,000	ASM, ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, ASF/PSI	6. Service delivery (Yellow)
Absence of specimen	• All specimen	A fully functioning	Mapping of VL sampling sites in	HLAB OHSS	$50,000	ASM	6. Service delivery

referral transportation network	from PEPFAR supported sites are linked to a molecular laboratory • Effective national/provinc ial specimen referral transportation system establish and adopted • Increased of VL laboratory coverage • Availability of norms and directives on lab equipment for VL • Increase of human resources capacity to run molecular labs	specimen transportation system including all VL laboratories is implemented Lab policy updated and disseminated Lab staff trained Number of service interruption days in molecular lab experienced Number of specimen performed	Katanga (Lualaba-Pweto-Kasenga)	PDCS			(Yellow)
			Organization of a reliable sample referral transportation system	HLAB OHSS	$250,000	ASM, ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, ASF/PSI	6. Service delivery (Yellow)
			Support workshop and photocopying of documents	HLAB OHSS PDCS	$20,000	ASM	2. Policies and governance (Yellow)
			Training and refresh training of molecular lab staff	HLAB OHSS PDCS	$150,000	ASM	7. Human Resources for Health (Yellow)
			Support the monitoring of VL specimen collection for eligible patients on ART	HLAB OHSS	$60,000	ICAP, EGPAF, SANRU, PROSANI Plus, IHP, PROVIC Plus, ASF/PSI	9.Quality Management (Red) 10.Laboratory (Yellow)

	• Well-functioning of VL laboratories experienced for specimens coming from PEPFAR sites • Increase of VL specimen performed for patients on ART in PEPFAR sites						
Inappropriate supply chain system	• Establishing of a good supply chain system able to respond to the need of each VL lab • No distribution issue of commodities experienced	Implementation of a good supply chain system Number of days stock out	Support the National forecasting and EID/VL TWG meeting	HLAB OHSS PDCS	$20,000	ASM	1. Planning and Coordination (Light Green)
			Support the reagents/consumables delivery to molecular labs	HLAB OHSS PDCS	$20,000	ASM	8. Commodity security and supply chain (Red)
Weak of Laboratory	• Routine data	Number of result returned to	Implementation and support of LIS in	HLAB OHSS	$150,000	ASM	15. Performance

informatics system (LIS)	collection tools adopted and implemented in the NHIS • No delay in result returned to clinicians/ patients • Good quantification base on previous performance	clinicians/patients (TAT) Implementation of LIS	molecular lab	PDCS			Data (Yellow)
			Support the monitoring molecular lab data base	HLAB OHSS PDCS	$10,000	ASM	15. Performance Data (Yellow
TOTAL					**$770,000**		

6.2 Critical Systems Investments for Achieving Priority Policies

Based on a thorough analysis of DRC COP 16 planning documents, including the Sustainability Index Dashboard, Data Pack, PBAC, and National Strategic Plan for HIV/AIDS 2014-2017, as well as a review of gaps identified in the treatment and prevention cascade, the DRC PEPFAR team identified the lack of a national policy for Test and Start, lack of training of providers, and the lack of an efficient and effective supply chain and commodities tracking system, and the top three systems barriers that are most critical to address to support the successful implementation of Test and Start. In order to ensure availability of critical treatment services, the team identified the challenge of accessing drugs for ART, poor management capacity of CBOs, and the challenges of avoiding stock outs and ensuring a regular supply of HIV-related commodities, whether testing kits, ARVs, condoms, viral load reagents, etc…

Table 6.2.1. Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones	Proposed COP Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Commodity security and supply chain: Frequent stock-outs of key HIV commodities.	Reduced expires and/or stock-outs of key HIV commodities	Quantification fora occur quarterly and are widely attended	Support national and provincial quantification of HIV commodities	OHSS	$100,000	GHSCP	Commodity Security and Supply Chain (Red)
		Coordination occurs through formal reporting structures and meetings at various levels in the health system	Support/ establish central and provincial level technical groups and committees	OHSS	$35,000	GHSCP	
		Relevant management staff track function-specific key performance indicators	Develop provincial performance management plans with indicators and incentives	OHSS	$150,000	GHSCP	

		Improved consumption data management	Strengthen automated processes for data aggregation, analysis, and sharing	OHSS	$165,000	GHSCP	
		Increased supply chain cost-efficiency and information visibility	Re-design overlapping distribution streams in the broader health system and various actors and levels that support multiple logistics functions, including sample transportation	OHSS	$145,000	GHSCP	
		Improved distribution system	Support last mile distribution of HIV commodities	HTXS, HVCT, HBHC, PDCS, MTCT	$105,775	GHSCP	
TOTAL					$707,775		

Table 6.2.2. New and Efficient Service Delivery Models

Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones	Proposed COP Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Policy: Current policy lacks conformity with most recent WHO guidelines	Updated policy based on WHO guidelines for efficient service delivery models. Implementation plan for more efficient service delivery model based on better understanding of the barriers and enablers	Availability of new ART and care guidelines	Provide technical assistance to the MOH to revise and disseminate ART and care guidelines	HTXS HBHC	$45,000	ICAP	Policies and Governance (Yellow) Service Delivery (Yellow) Technical & Allocative Efficiencies (Red)
		Availability of task-shifting guidelines	Provide technical assistance to the MOH/PNLS to develop and disseminate a comprehensive task-sharing policy, guidelines and tools	OHSS HBHC	$135,000	ICAP	
		Health providers briefed on new	Strengthen clinic and community sites capacity to	HTXS HBHC	$80,000	ICAP and EGPAF	

		WHO guidelines	pilot more efficient service delivery models for stable patients through clinical mentoring,				
		Availability of community service delivery	Support Adoption of policy, guidelines and reporting tools related to the community drug distribution points (PODI+)	HBHC, HTXS	$45,000	ICAP	
		Availability of community service delivery	Pilot 10 PODI for stable patients in high volume health zones	HBHC, HTXS,	$450,000	ICAP and EGAPF	
HRH: Staff not adequately trained in commodity management and forecasting.	Health facilities able to manage 3-monthly patient visits and provide 3-months of ARVs. Regional Drug Stores (CDR) and site level staff working together to forecast and meet patient need.	Trained health system personnel consistently follow SOPs for logistics activities	Support cascade training on logistic and supply chain improvements	OHSS	$200,000	GHSCP	Commodity Security and Supply Chain (Red) Human Resource for Health (Yellow)
			Conduct supportive logistic supervision within PEPFAR-supported health zones	OHSS	$35,000	GHSCP	
			Develop standard operating procedures, supervision and monitoring tools	OHSS	$45,000	GHSCP	
Commodity procurement and supply not aligned with policy requirements of providing longer prescriptions of ARVs for stable patients	An established LMIS and reporting system support visibility of demand at relevant administrative levels	Availability of ARV dispensing tools at PEPFAR-supported clinic and community sites	Conceive and disseminate ARV dispensing register	OHSS	$25,000	GHSCP	Commodity Security and Supply Chain (Red)
			Endow PODI with supply chain management tools		$15,000	GHSCP	
Structural and	Improved enabling		Assessment of which		$75,000	ICAP, EGPAF,	Civil Society

legal barriers, including discrimination and stigma hampered community service models	environmental and structural factors impacting the HIV community care and treatment programming PLHIV access community care and treatment services without fear of discrimination		differentiated service models approach is relevant to the site among the options, populations with increased risk of HIV infection and specific needs			SANRU, PROSANI Plus, IHP, PROVIC Plus, ASF/PSI	engagement (Yellow) Quality Management (Red)
		Data are reviewed and use for program improvement	Build capacity of NGO on data collection, analysis, application practices		$45,000	TBD/PD Small grant	
			Community support/dialogue for addressing stigma and discrimination issues		$75,000	TBD/PD Small grant	
TOTAL					**$1,270,000**		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3: Other Proposed Systems Investments							
Systems Category	**Activity**	**Activity addresses: 1) First 90; 2) Second 90; 3) Third 90; 4) Sustained Epi Control**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Partner**	**Relevant SID Element and Score (if applicable)**
Laboratory							
Lab training, QA/QI, mentoring/supervision	• Targeted training of PEPFAR lab staff at the KSPH regional training center (EID/VL sample collection, management, HIV RT. Logbook, data tools, test and start, etc.)	First 90, Second 90 Third 90	• The inaccurate screening result has decreased • The RTQII process on site is implemented • The quality of EID/VL specimen collected is improved and the number has increased • The LTFU proportion from HIV testing entry point to ART entry point has decreased	$145,000	HLAB	EGPAF, SANRU	7. Human Resources for Health (Yellow)
National TB lab strengthening including GeneXpert, MDR TB	Support the TB NCP (National Control Program) through	First 90	The screening rate in HIV-TB co infected patients has increase	$25,000	HLAB	ICAP, EGPAF, SANRU, PROVIC, IHP,	9.Quality Management (Red)

monitoring and culture (system and capacity development)	PEPFAR to develop the capacity of program at national and provincial level					ASF/PSI	
Ensure proper biosafety (injection safety and waste management)	• Organize biosafety (injection safety and waste management) training for staff • Strengthen the lab biosafety (injection safety and waste management) capacity through purchase of containers and incinerators	First and third 90	The waste management at site level is well organized	$230,000	HMIN	ICAP, EGPAF, SANRU, PROVIC, IHP	6.Service Delivery (Yellow)
Maintenance and repair of laboratory equipment at PEPFAR supported clinical sites	• Develop and implement a laboratory equipment maintenance program	First and third 90	No service interruption experienced due to equipment issue	$160,000	HLAB	ICAP	8. Commodity Security and Supply chain (Red) 10.Laboratory (Yellow)
Expand QA program for HIV testing including Proficiency Test (PT panel) and HIV related	• Implement the HIV quality improvement	First 90	Laboratory and others entry point staff competency to perform HIV test is improved	$170,000	HLAB	ASM, EGPAF, ICAP	6.Service Delivery (Yellow) 8.Quality

POC	initiative • Organize EQA for biochemistry, hematology and CD4 count test						management (Red) 10.Laboratory (Yellow)
Support laboratory continuous quality improvements projects	• Mentoring the 6 first cohort of lab in the process • Train, insert and monitor the second cohort of 10 laboratories	First 90 Third 90	A good laboratory management has been put in plac	$300,000	HLAB	APHL	9.Quality Management (Red)
Quality assurance activities and capacity building of military lab network	• Training of military lab personnel on basic laboratory management procedures. • Implement quality assurance system in military facilities performing lab analysis (mentorship and supervisory visit by PNLS and CDC lab advisors)	First 90 Second 90	• All PEPFAR supported military laboratories have means and procedures in place to assure the quality of analysis performed. • All military EID and VL samples are timely processed and results are	$70,000	HLAB	ASF/PSI	9.Quality Management (Red)

	• Enrolling all military laboratories performing rapid testing in the National Proficiency test process. • Organizing a reliable military EID and VL sample transportation system		quickly given to HCWs and patients.				
Ensure proper biosafety (injection safety and waste management) of military lab network	• Training of military HCWs on injection safety and waste management • Providing injection safety materials and waste containers to all PEPFAR supported military sites • Build/refurbish incinerators at PEPFAR supported military sites	First 90 Third 90	All PEPFAR supported military sites have means and standard procedures to prevent biomedical transmission of HIV and other blood borne infections.	$100,000	HMIN	ASF/PSI	6.Service Delivery (Yellow) 9. Quality Management (Red) 10. Laboratory (Yellow)
Strategic Information							

	Strengthen the national Health Information System (HIS)	First 90 Second 90 Third 90 Sustained Epi Control	Policy Developed and Disseminated	$100,000	HVSI	TBD / CDC	2. Policies and Governance (Yellow) 13. Epidemiological and Health Data (Light green)
	Built host country institutional and organizational capacity for data management	First 90 Second 90 Third 90 Sustained Epi Control	• Data managers are trained • HIV / AIDS data collection validated and promoted at each level of the MOH pyramid	$200,000	OHSS	TBD/CDC	7. Human Resources for Health (Yellow) 9. Quality Management (Red) 13. Epidemiological and Health Data (Light green)
	Support web based electronic reporting system, Monitoring Evaluation and Surveillance Interface (MESI)	First 90 Second 90 Third 90 Sustained Epi Control	• Equipment and maintenance provided • Accurate and reliable data available for decision making at different levels of MOH pyramid • MESI implementation extended • Quarterly validation meeting at provincial	$400,000	HVSI	TBD / CDC	13. Epidemiological and Health Data (Light green)

			level supported • Provincial level supported				
	Support Host country for Data Quality improvement System	First 90 Second 90 Third 90 Sustained Epi Control	• Accurate, reliable timelines and complete data available for informed decision making • DQI process and data use, decision making initiated and effective • Technical capacity at provincial and national levels for implementation, coordination and supervision of activities related to HIV data management process reinforced • Routine DQA process supported	$100,000	HVSI	TBD / CDC	13. Epidemiological and Health Data (Light green)
	Strengthen Host country in Strategic Information Systems	First 90 Second 90 Third 90	• Provincial level estimates	$750,000	HVSI	UNAIDS (New IM)	13. Epidemiological and Health Data (Light green)

		Sustained Epi Control	developed • Integrated HIV & TB and Community database developed • Web application which transfers denominators from spectrum files to the local Electronic System introduced in National HSI				
	Support HIV/AIDS surveillance activities & HIV impact assessment activities	First 90 Second 90 Third 90 Sustained Epi Control	• Survey data processed • Survey report released and shared	$500,000	HVSI	TBD	13. Epidemiological and Health Data (Light green)
	Supporting the military coordination offices to ensure the national data collection and reporting	First 90 Second 90 Third 90 Sustained Epi Control	All PEPFAR supported military sites have means and tools to collect and report routine program data	$100,000	HVSI	ASF/PSI	13. Epidemiological and Health Data (Light green)
TOTAL				**$2,050,000**			
Supply chain Management							
	Use provincial systems for distribution	Sustained Epi Control	Regional Drug Stores improved warehousing and inventory management	$763,500	HVCT HBHC MTCT	GHSCP	Commodity Security and Supply Chain (Red)

			practices		HTXS PDTX PDCS		
TOTAL				**$763,500**			

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

In preparing COP16, PEPFAR DRC conducted a staffing assessment to determine the Level of Effort (LOE) and skills needed to continue the pivot from a PMTCT-focused program to a full continuum of care and treatment program, while reinforcing systems for SI, Lab and Supply chain, and increasing SIMS visits. PEPFAR DRC Scale-up HZs form two clusters in Lubumbashi and Kinshasa. While regular engagement and site visits with partners are feasible in Kinshasa, achieving sufficient oversight in Lubumbashi remains a challenge. To align resources with the increased focus in Haut Katanga, PEPFAR DRC will install a provincial team in Lubumbashi that will include three new positions: one Strategic Information Officers (CDC) one Lab Officer (CDC), and one driver (?). These staff will join the existing medical officer (CDC), and planned SI officer (USAID) and Treatment Officer (USAID), to form the Lubumbashi team. Per OVC TWG recommendations, the team will also hire an OVC Advisor (USAID) to increase OVC technical expertise and oversight. An Administrative assistant for the PEPFAR Coordination office will provide assistance with scheduling and documenting meetings, travel, etc. In total, the OU is requesting seven new positions. PEPFAR is working with the Regional Security Office to identify a suitable location and ensure appropriate security measures are in place before the Lubumbashi team is installed. Space for the Kinshasa-based PEPFAR positions will be available when office expansion plans are completed at the USAID/MOBIL office by the end of 2016.

A staffing assessment conducted in 2014 showed a vacancy rate of 40% for the DRC program. Significant hiring efforts have led to a reduced vacancy rate in March 2016 of 16%. There are nine previously approved positions that are vacant including six for CDC: Deputy Technical Director of Programs, Cooperative Agreement Specialist, Cooperative Agreement Manager, Operations Manager, and Treatment Specialist, two for State: PEPFAR Coordinator and the PEPFAR Strategic Information Liaison, and one for USAID: Global Fund Liaison (GFL), however an Interim GFL has been in place since July 2015. The hiring process is underway for all of these positions, with vacancies longer than 6 months taking priority. The team is requesting to change the status of the previously-approved SI Liaison position in the PEPFAR Coordination office from a locally hired position to an international USPSC/TCN position.

PEPFAR DRC is balancing interagency business process coverage and intra-agency partner management and technical roles, by planning an appropriate mix of both technical and managerial staff and ensuring job descriptions reflect expected LOE for key activities.

US Government oversight is a focus for the FY17 period. The PEPFAR team is planning for 35 out of 55 total staff members to spend an average of 11 days per quarter conducting SIMS visits, to ensure quality and remediate poorly performing sites (six Lubumbashi program staff expected to spend an average of 15 days/quarter).

Geographic size, economic and political instability, and limited transportation and infrastructure contribute to increased challenges and the high cost of doing business in the DRC. The DRC CODB request is slightly higher this year due to the costs of establishing and staffing a new sub-office in

Lubumbashi. Without requested CODB funds, it would difficult to establish this office or expand program oversight in Lubumbashi.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities
Site level	**HTC** Clinical settings: PITC (pregnant women/partners/family members of index cases, EID, TB, malnourished, STI, FP and inpatients), and disclosure for children and adolescents and linkage with OVC programs Other facilities: Stand-alone VCT for KP and PPs (CSWs, FSWs, IDUs, MSM, miners, truckers, military, AGYW and their clients) Community-based: outreach and mobile for KP and PP and in high prevalence areas Linkages to care and treatment, including PMTCT Procurement and distribution of RTK, including DBS, DNR as well as injection safety and bio-security supplies. Quality Assurance and Quality Improvement (Site Level HIV Proficiency Testing) **Community Prevention** Targeted risk assessment and provision of risk reduction information, education and/or counseling to accurately gauge and personalize risk for HIV infection for priority populations (KP, AGYW and their partners, miners, truckers, military) Targeted informational sessions on HIV testing and counseling for AGYW and	**Community Prevention** Linkages to other health, social, and legal services Treatment of GBV and expansion/improvement of FP for Adolescent Girls and Young Women (AGYW) Prevention, diagnosis and treatment of co-infections such as Viral Hepatitis Implementation of the PEPFAR Ethical framework for engagement of KP (KP status disclosure policy, confidentiality protocols, informed consent and data safety procedures)

their sexual partners and referral to appropriate HTC services

Prevention with Positives

Peer education and outreach for key and priority populations

Sexual and drug use assessment and risk reduction counseling

Condom and condom-compatible lubricant promotion and distribution for KP and other priority populations including miners, truckers, military, AGYW and their sex partners

Sexually Transmitted Infections (STI) screening and treatment

Male involvement in PMTCT

Care and Treatment (including key populations)
Biological monitoring (Viral load) of HIV positive patients.

Clinical monitoring of HIV positive patients (WHO staging).

Monitoring and management of side effects from ART : Creatinine for patients on TNF and Hemoglobin for patients on AZT

Scale up of pediatric HIV treatment

Evidence-based adherence and retention programs (mentor mothers, patient experts, Quality improvement initiatives, Peer Health Workers (PHW) care).
Support retention and

Care and Treatment (including key populations)
Strengthen HIV Support group approaches to all health facilities in order to improve follow-up and promote the continuum of care

Biological monitoring (targeted CD4, for Lualaba HIV positive patients (including peds).

Pediatric facility referral to Community care and support services

Nutrition Assessment Counseling and Support of HIV positive patients
Demand creation for uptake of HIV services in the facility and community

Treatment Literacy. Training /mentoring health providers (facility and community) on ARV management

Strengthen TB/HIV program monitoring and evaluation (M&E). Implement, track, and report on TB screening among PLHIV

Support functioning of GenXpert MTB/RIF

Developing specimen transportation networks

Establish and strengthen referral mechanisms to ensure cross referral between clinic and community services

Implement QM/QI initiatives at the facility/community level approach

Breastfeeding support
Management of other OIs. Screen and refer for treatment of opportunistic infections among PLHIV.

Community Prevention
Linkages to other health, social, and legal services

Management of GBV and expansion/improvement of FP for Adolescent Girls and Young Women (AGYW)

Implementation of the PEPFAR Ethical framework for engagement of KP (KP status disclosure policy, confidentiality protocols, informed consent and data

Care and Treatme
key populations)
Palliative care (pain
symptom managem
life care)

Mental Health and
substance/alcohol a
HIV care

Hepatitis B screenir

Water, Sanitation, H
(WASH)

Food package provi

Laboratory monitor
testing, glucose.

Distribution of inse
treated bed nets to
households.

monitoring of mothers on ART once initiated.

Cotrimoxazole Preventive Therapy of HIV positive patients (including mothers and HIV-exposed infants); Clinical provision of CTX to eligible PLHIV; Integration of CPT in MCH and TB; Community distribution; Supply Chain (Procurement, distribution, logistic support, HSS)

Provision of ARV and other commodities. ARVs for PMTCT according to national protocols: B+ option. Drugs, tests kits and consumables procurement (ARV,CTX, RTKs, condoms and lubricants, DBS, bio-safety consumables)

INH for eligible HIV positive patients

Support TB infection control in clinical settings (TBIC)

TB screening and referral for PLHIV

Integration of TB and HIV activities to ensure linkage and retention

ART to PLHIV per WHO Test/Start strategy and Country guidelines

Positive Health, Dignity, Prevention (PHDP) (HIV serostatus disclosure counseling and partner HTC; FP counseling and services; Risk reduction counseling and condom and appropriate lubricant provision; STI screening and management; Adherence counseling and support, prevention

safety procedures)

OVC

Case Management

- Mapping services within targeted communities and developing service directories
- Supporting the development of national MIS
- Training in case management for CLHIV and voluntary children's officers (including tracing of children LTFU) within PEPFAR catchment areas.

Strengthening referral mechanisms and other systems for linking non-HIV clinical and social services (cross-referrals)

Program/system support
Mapping and size estimation studies

interventions for PLHIV in TB clinical settings.

Tracking mother-infant pairs

OVC

Case Management

- Assessing child & family socio-economic status(across all areas: healthy, safe, stable, schooled)

- Developing care/ case management plans for children and families with monitoring of referral completion and stated case closure goals

Access to Health/ HIV Services
Promotion of EID and confirmatory HIV testing (E.g. within early childhood development (ECD) programs, etc.)

Integrating adherence assessment, counselling and support into routine household support

Coordination with NACS (E.g., referral of suspected malnutrition cases, education)

Facilitating uptake of and monitoring completion of referrals for:

- Nutrition and food security programs
- TB/HIV testing, care and treatment services for all children and family members of index cases

	• Child survival services • ALHIV for SRH and FP services, including AYFS **Program/system support** *SI* Implementing OVC related baseline studies *SCMS Supply Chain* Support risk mitigation (disposal of expired USG-procured ARV, redeployment of supplies)	
Health Zone level	**OVC** *Case Management* Train Child Protection Committee on case management. *Access to Health/ HIV Services* Strengthening referral mechanisms and other systems for linking non-HIV clinical and social services (cross-referrals. *Child Protection* Supporting Community child protection/ GBV prevention and response activities (including emergency food and shelter for abused survivors (generally required for <10% of cases, and referrals to other services) *Economic Strengthening* Supporting access	**OVC** *Case Management* • Mapping services within targeted communities and developing service directories Carrying out child rights awareness school block grants or support for ECD centers Improving education quality, especially making classroom environments gender and HIV sensitive Supporting community education councils and PTAs Succession planning Program/system support Site-level recruitment, deployment, retention of HRH Minor renovation of health facilities **Care and Treatment** (including key populations) Treatment Literacy. Training /mentoring health providers (facility and community) on ARV management Strengthen TB/HIV program monitoring and evaluation (M&E). Establish and strengthen referral mechanisms to ensure cross referral between clinic and community services Implement QM/QI initiatives at the facility /community level approach

		to and uptake of social protection efforts (such as social grants, cash transfer programs, bursaries, etc.)	**Program Support** *Supply Chain Management* Disseminate logistic and supply chain standard operating procedures (e.g. inventory, warehousing, etc.)
	Education		Support logistic supervision and mentorship
		Providing temporary school block grants to promote enrollment and progression	Support HZ to coordinate a pooled warehousing of second line regimens
			Improve warehousing conditions
			Reproduce and disseminate logistic tools (e.g. stock cards)
Provincial level	**OVC** Strengthen OVC Technical Working Group Support Supportive supervision Conduct network analysis and referral strengthening Revise OVC/Child protection key indicators selection, data collection and reporting tools,	**OVC** Strengthening government-managed and case management systems to prevent and respond to child abuse and support family placement and permanency for children Strengthening structures for community-based mediation of child abuse cases Dissemination of Child protection laws Carrying out market assessments for Income generating Activities (IGAs) Targeted food security initiatives	
		Care and Treatment (including key populations) Treatment Literacy. Training /mentoring health providers (facility and community) on ARV management Strengthen TB/HIV program monitoring and evaluation (M&E). Implement, track, and report on TB screening among PLHIV	
		Program/system support *LAB PMTCT* Support procurement of EID and VL reagents and sample collection	

	consumables • Supply of CD4 cartridges for testing for Lualaba • Ensuring the QA for CD4 test installed in sites	**Program/system su***LAB HIV Care and Treatmen* • Maintenance and/or certification of equipme
National level	**OVC** Strengthen HIV sensitive child welfare and protection knowledge and skills of Ministry of Social Affairs officials Strengthen the availability, quality and use of child-focused social welfare data for policy formulation, advocacy, budgeting, action planning, and service strengthening, including for children affected by HIV and other adversities Strengthen OVC M&E systems Support development of case management and referral guidelines to improve HIV pediatric uptake	**OVC** Strengthen the legal and policy framework for vulnerable children Conduct a Rapid HIV Sensitive Child Protection and Welfare Systems Mapping and Assessment. Strengthen Ministry of Social Affairs' capacity to advocate for increased budget allocation M&E systems for National child protection/ social welfare efforts M&E systems for National child protection/ social welfare efforts Supporting vocational training and other individual HES activities Carrying out market assessments for Income generating Activities (IGAs) Facilitating access to primary (and secondary education for girls) through long-term or open-ended subsidies Providing long-term or open-ended school block grants or support for ECD centers Improving education quality, especially making classroom environments gender and HIV sensitive Supporting community education councils and PTAs Succession planning Program/system support Support MOH/NACP to develop clinical care and PHDP guidelines, standards and tools Site-level recruitment, deployment, retention of HRH HRH performance and quality assessment.

Revise national HTC policies and guidelines for inclusion of disclosure process and deletion of requirement of parental consent for adolescents

Support the development of national TB/HIV guidelines

Support national (MoH/PNLS) revising ART guidelines and policies, including PMTCT related standard guidelines.

Regular supportive supervisory visits by provincial MOH NAC office and PEPFAR IPs to ensure high quality services and data collection

SI and M&E technical considerations for pediatrics (routine program monitoring, data quality and use, evaluation, assessing M&E tools and systems to support linkage and retention, quality management and QI)

Surveillance for HIV drug resistance

Ensure Testing QA

Supply relevant tools (registers, medical chart, etc.) to health and community facilities

Developing standard procedures for identifying and tracking ART patients (defaulted, missing appointments, etc.).

Provide standard adherence support protocol for documenting all the following core elements:
1) Adherence counseling prior to ARV treatment initiation
2) Routine adherence assessments during ARV therapy
3) Counseling interventions for patients with poor adherence

Scale-up of national EID plan
PMTCT Training and mentoring(Tutoring) for providers

Program/system support
SCMS Routine Supply Planning

- Support to the national supply chain strategic plan process
- Construct the Central Medical Store (Warehouse-in-a-box)

SCMS Supply Chain

- Procure and distribute isoniazid.

SCMS Use of Site Level Stock Data

- Support the national Logistic Management Information System design roadmap implementation

- Develop and operationalize integrated distribution systems and networks, and information-management systems with Family Planning program.

Program support
SCMS Routine Supply Planning
Technical assistance to GFATM PRs supply plan
TA to national HIV supply chain committee

Conduct regular inventory management assessment tool

Conduct national and provincial (3) quantification for ARVs, lab commodities and other drugs used in OI and STI.

Coordinate use of existing stocks of ARVs and prepare a smooth transition on TDB-based regimens

SCMS Use of Site Level Stock Data
Strengthen collaboration between GF SRs and PEPFAR IPs (Consolidate stock data from GF PRs and PEPFAR IPs)

Supply Chain Segmentation
Procure and distribute essential HIV commodities [TDF-based regimens, CTX, RKT, and essential testing supplies (gloves, capillary tubes, lancets, etc.)].

Support risk mitigation

LAB HIV Care and Treatment

- Supply of CD_4 cartridges for testing
- Ensuring the QA for CD_4 equipment installed in sites
- Lab biosafety (waste management, biosafety)
- Maintenance and/or certification of equipment
- Implementation of an internal quality assurance program for all HIV core tests
- Support for epidemiological surveys (RDTs, equipment and method assessment)
- Development of a VL scale-up plan

Program/system s
SCMS Routine Supp

- Design a p plan (PEP

SCMS Supply Chain Segmentation

- Store HIV in partner

LAB HIV Care and T

- Maintenar certificatio equipmen

(disposal of expired USG-procured ARV, redeployment of supplies)

LAB HIV Care and Treatment

- Lab biosafety (waste management, biosafety)
- Biological monitoring (Hemoglobin, Creatinine,)
- Strengthening lab capacity (training of staff, etc.)
- Development of a VL scale-up plan

Support of laboratory reagents (DNA PCR and VL) in the PEPFAR focus provinces (Katanga, Kinshasa)

LAB PMTCT

Support procurement EID reagents and sample collection consumables

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

	Core Activities	Near-core Activities	Non-core Activities
HTC	Clinical settings: PITC (pregnant women/partners/family members, EID, TB, malnourished, STI, FP), and disclosure for children and adolescents and linkage with OVC programs Other facilities: Stand-alone VCT for KP and PP populations (CSWs, FSWs, IDUs, MSM, miners, truckers, military, AGYWs and their clients) Community-based: outreach and mobile for KP and PP populations, and in high prevalence areas Ensure linkage to care and treatment, including PMTCT Procurement and distribution of RTK, including DBS, DNR. Quality Assurance and Quality Improvement (Site Level HIV Proficiency Testing)		
Care and Treatment (including key populations)	Biological monitoring (Viral load) of HIV positive patients. Clinical monitoring of HIV positive patients (WHO staging). Monitoring and management side-effects from ART	Social Services (Economic Strengthening Services): saving groups Strengthen HIV Support group approaches to all health facilities in order to improve follow-up and promote the continuum of	Palliative care (pain and symptom management; are) Mental Health and substance/alcohol abuse and Hepatitis B screening Providing food package

	Scaling up pediatric HIV treatment Evidence-based adherence and retention programs (mentor mothers, patient experts, Quality improvement initiatives, Peer Health Workers (PHW) care). Support retention and monitoring of mothers on ART once initiated. Cotrimoxazole Preventive Therapy of HIV positive patients (including mothers and HIV-exposed infants); Clinical provision of CTX to eligible PLHIV; Integration of CPT in MCH and TB; Community distribution; Supply Chain (Procurement, distribution, logistic support, HSS) Provision of ARV and other commodities. ARVs for PMTCT according to national protocols: B+ option. Drugs, tests kits and consumables procurement (ARV,CTX, RTKs, condom, DBS) INH for HIV positive patients TB diagnosis in HIV clinics Support TB infection control in clinical settings (TBIC) TB screening and referral for PLHIV Integration of TB/HIV care and treatment to ensure linkage and retention ART to PLHIV per WHO Test/Start strategy and country guidelines Positive Health, Dignity, Prevention (PHDP) (HIV sero-status disclosure counseling and partner HTC; FP counseling and services; Risk reduction education and condom provision; STI assessment and treatment;	care Biological monitoring (targeted CD_4, hemoglobin, creatinine, ASAT, ALAT) of HIV positive patients (including peds) DNA PCR reagents Pediatric facility referral to Community care and support services Nutrition Assessment Counseling and Support of HIV positive patients Demand creation for uptake of HIV services in the facility and community Treatment Literacy. Training /mentoring health providers (facility and community) on ARV management Strengthen TB/HIV program monitoring and evaluation (M&E). Implement, track, and report on TB screening among PLHIV Support functioning of GenXpert MTB/RIF Developing specimen transport networks Establish and strengthen referral mechanisms to ensure cross referral between clinic and community services Implement QM/QI initiatives at the facility /community level approach Breastfeeding support Management of other OIs.	Laboratory monitoring: protein testing, glucose Distribution of insecticide treated bed nets to P households

	Adherence counseling and support, prevention interventions for PLVIV in TB clinical settings. Tracking mother-infant pairs	Screen and refer for treatment of opportunistic infections among PLHIV.
	Targeted risk assessment and provision of risk reduction information, education and/or counseling to accurately gauge and personalize risk for HIV infection for priority populations (KP, AGYW and their partners, miners, truckers, military) Targeted informational sessions on HIV testing and counseling for AGYW and their sexual partners and referral to appropriate HTC services Prevention with Positives Peer education and outreach for key and priority populations Sexual and drug use assessment and risk reduction counseling	Linkages to other health, social, and legal services Treatment of GBV and expansion/improvement of FP for adolescent Girls and young Women (AGYW) Prevention, diagnosis and treatment of co-infections such as Viral Hepatitis Implementation of the PEPFAR Ethical framework for engagement of KP (KP status disclosure policy, confidentiality protocols, informed consent and data safety procedures)
Community Prevention	Condom and condom-compatible lubricant promotion and distribution for KP and other priority populations including miners, truckers, military, AGYW and their sex partners Sexually Transmitted Infections (STI) screening and treatment Male involvement in PMTCT	
OVC	Case Management • Assessing child & family socio-economic status(across all areas: healthy, safe, stable, schooled) • Developing care/ case management plans for children	Case Management • Mapping services within targeted communities and developing service directories • Supporting the development of national MIS • Training in case

and families with monitoring of referral completion and stated case closure goals
- Implementing baseline studies

Access to Health/ HIV Services

- Promotion of EID and confirmatory HIV testing (E.g. within early childhood development (ECD) programs, etc.)
- Integrating adherence assessment, counseling and support into routine household support
- Coordination with NACS (E.g., referral of suspected malnutrition, education)
- Facilitating uptake of and monitoring completion of referrals for:
  - Nutrition and food security programs
  - TB/HIV testing, treatment and care services for all children and partners of index cases
  - Child survival services
  - ALHIV for SRH and FH services, including AYFS

Child Protection

- Supporting Community and national level child protection/ GBV prevention and response activities (including emergency food and shelter for abuse survivors (generally required for <10% of cases, and management for CLHIV and voluntary children's officers (including tracing of children LTFU) within PEPFAR catchment areas.

Strengthening referral mechanisms and other systems for linking non-HIV clinical and social services (cross-referrals)

Carrying out child rights awareness campaigns in targeted communities

Strengthening structures for community-based mediation of child abuse cases

Dissemination of Child protection laws

M&E systems for National child protection/ social welfare efforts

Supporting vocational training and other individual HES activities

Carrying out market assessments for Income generating Activities (IGAs)

Linking businesses/agricultural projects to markets/value chain development

Targeted food security initiatives

Facilitating access to primary (and secondary education for girls) through long-term or open-ended subsidies

	referrals to other services) • Supporting clinic-based child abuse and GBV response services (including emergency medical services/PRC) • Facilitating birth registration • Positive Parenting skills building (including topics on adolescent risk, HIV disclosure, child health & development knowledge	Providing long-term or open-ended school block grants or support for ECD centers Improving education quality, especially making classroom environments gender and HIV sensitive Supporting community education councils and PTAs Succession planning
Economic Strengthening • Facilitating group-based Household Economic Strengthening (HES) activities, such as savings groups • Supporting access to and uptake of social protection efforts (such as social grants, cash transfer programs, bursaries, etc.) • Addressing psychosocial health among children and their caregivers through individual, group-based and relationship based activities		
Education • Facilitating access to primary and secondary education through temporary and targeted support for: uniforms, school fees, exam fees, adult mentors - cost-shared • Providing temporary school block grants to promote enrollment and progression		

	• School-based psychosocial support, (including Teacher psychosocial support for children [cash & care]) • Supporting early childhood development (ECD) – (in coordination with PMTCT & Pediatric HIV) • Integrating ECD into HIV care and treatment for children under five	

Program/system support	Implementation of revised national ART (2015 WHO guidelines) Develop standard procedures for identifying and tracking ART patients (defaulted, missing appointments, etc.). Provide standard adherence support protocol for documenting all the following core elements: 1) Adherence counseling prior to ARV treatment initiation 2) Routine adherence assessments during ARV therapy 3) Adherence counseling interventions for patients with poor adherence *SCMS Routine Supply Planning* • Technical assistance to GFATM PRs supply plan • TA to national HIV supply chain committee • Conduct regular inventory management assessment • Conduct national and provincial (3) quantification for ARVs, lab commodities and other drugs used in OI and STI. • Coordinate use of existing stocks of ARVs and prepare a smooth transition on TDB-based regimens *SCMS Use of Site Level Stock Data* • Support quarterly provincial review of consumption data, product loss, transfer and restocking level for aggregation and use in decision-making. • Strengthen collaboration between GF PRs and PEPFAR IPs (Consolidate stock data	Support MOH/NACP to develop clinical care and PHDP guidelines, standards and tools. Reproduce and disseminate tools (educational tools, data collection tools, etc.) Assist MoH with development of an ART transition approach (priority sub-populations, priority regimens, timeline, etc.) Assist MoH with development of QI guidelines for care and treatment. Assist MoH with development of key population policy: guidelines, protocols and tools. Expanding task-sharing/scopes of practice for HIV service delivery In service continuous professional education along HIV continuum of response Pre-service education for nurses and at masters level Pre-service education standardization of HIV curriculum Reinforce leadership of national council for nurses Promoting pre-/in-service training and mentoring on gender and diversity issues for relevant professions Site-level recruitment, deployment, retention of HRH	*SCMS Routine Supply Planning* • Design a parallel supply plan (PEPFAR *SCMS Supply Chain Segmentation* • Store HIV commodities in partners 'of • Procure AZT/3TC/NVP regimens

from GF PRs and PEPFAR IPs)

SCMS Monitoring and Supportive Supervision

- Support DPS in their technical and material capacity to fully play their supervisory role with the health facilities

SCMS Supply Chain Segmentation

Procure and distribute essential HIV commodities [TDF-based regimens, CTX, RKT, and essential testing supplies (gloves, capillary tubes, lancets, etc.)].

- Support risk mitigation (disposal of expired USG-procured ARV, redeployment of supplies)

Lab HIV Test and Counseling

- HIV RTKs
- Quality assurance for HIV rapid testing including proficiency testing (PT panel) in Provincial HIV reference laboratories in Kinshasa and Lubumbashi
- Targeted training of lab personnel at provincial and PEPFAR site level (EID and VL sample collection/ management, HIV RTKs, logbook, data tools, etc.)
- Proficiency testing (PT panel) or Quality assurance for HIV RKTs)
- TB screening and referral for PLHIV

Lab HIV Care and Treatment

- VL testing for patients on ART

HRH performance and quality assessment.

Revise national HTC policy and guidelines for inclusion of disclosure process and deletion of requirement of parental consent for adolescents

Support the development of national TB/HIV guidelines

Support national (MoH/PNLS) in updating ART guidelines and policy including PMTCT related standard guidelines.

Regular supportive supervisory visits by provincial MOH NAC office and PEPFAR IPs to ensure high quality services and data collection

SI and M&E technical considerations for pediatrics (routine program monitoring, data quality and use, evaluation, assessing M&E tools and systems to support linkage and retention, quality management and QI)

Surveillance for HIV Drug Resistance

Ensure QA for Testing

Support GDRC in the adoption and contextualization of WHO consolidated guidelines on HIV prevention, diagnosis, treatment, and care for Key Populations

Minor renovation of health facilities

- TB lab diagnosis (GenXpert for TB /HIV patients) at national TB program and PEPFAR provincial levels
- EID in PEPFAR supported provinces (lab reagents, sample collection consumables, data bases, data collection tools, distribution to collection sites)
- Implementation of a reliable specimen transportation network in PEPFAR supported provinces (EID, VL, TB, biological monitoring)

Lab PMTCT

- HIV Screening with RTKs
- Support procurement EID reagents and sample collection consumables

Supply relevant tools (registers, medical chart, etc.) to health and community facilities

Scale-up of national EID plan

PMTCT Training and mentoring (Tutorial) for providers

SCMS Routine Supply Planning

- Support to the development of the supply chain national strategic plan process
- Support CDRs to improve storage and delivery processes
- Construct the Central Medical Store (Warehouse-in-a-box)

SCMS Use of Site Level Stock Data

- Support the national Logistic Management Information System design roadmap implementation

SCMS Supply chain Segmentation

- Procure and distribute Isoniazid.
- Develop and

operationalize integrated distribution systems and networks, and information-management systems with Family Planning program.

Lab HIV Care and Treatment

- Strengthening lab capacity (training of staff, etc.)

Table A.3 Transition Plans for Non-core Activities						
Transitioning Activities	**Type of Transition**	**Funding in COP 15**	**Estimated Funding in COP 16**	**# of IMs**	**Transition End date**	**Notes**
Care and Treatment (including key populations)						
Palliative care (pain and symptom management; end of life care)	Phasing out	0	NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, ICAP, SANRU, PSI
Mental Health and substance/alcohol abuse and HIV care	Phasing out	0	NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, ICAP, SANRU, PSI
Hepatitis B screening	Transition to Government or local partner		NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, ICAP, SANRU, PSI
Laboratory monitoring: protein testing, glucose.	Transition to Government or GFATM			7	Sept 2016	PRoVIC, IHP, KIMIA, MALAMU, ICAP, SANRU, PSI
Distribution of insecticide treated bed nets to PLHIV and households.	Phasing out	0	NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, ICAP, SANRU, PSI
SCMS Routine Supply Planning- Design a parallel supply plan (PEPFAR only)	Phasing out	0	NA	1	Sept 2016	SCMS
SCMS Supply Chain Segmentation- Store HIV commodities in partners' offices	Phasing out	0	NA	7	Sept 2016	ProVIC, ICAP, KIMIA, SANRU, PSI, SCMS

• **Maintenance and repairing of laboratory equipment at PEPFAR supported clinical sites.**	Transition to Government or local partner	Sept 2016
Totals		

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US 7,507,680	**$US 58,490,320**	**$US 65,998,000**

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$2,552,936
HVAB	Abstinence/Be Faithful Prevention	$195,000
HVOP	Other Sexual Prevention	$2,419,073
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$65,825
HMIN	Injection Safety	$636,207
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$3,616,653
HBHC	Adult Care and Support	$5,798,925
PDCS	Pediatric Care and Support	$1,882,228
HKID	Orphans and Vulnerable Children	$1,040,637
HTXS	Adult Treatment	$13,850,913
HTXD	ARV Drugs	$10,745,355
PDTX	Pediatric Treatment	$1,932,460
HVTB	TB/HIV Care	$3,245,690
HLAB	Lab	$1,023,253
HVSI	Strategic Information	$2,034,261
OHSS	Health Systems Strengthening	$2,645,995
HVMS	Management and Operations	$4,804,909
TOTAL	**New Funds**	**$58,490,320**